

FILED NOV 10 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

35319

State File No. \_\_\_\_\_

REG. DIST. NO. **318**

PRIMARY REG. DIST. NO. **1003**

Registrar's No. **9390**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Mo.</b> b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give town) <b>St. Louis</b>		c. CITY (If outside corporate limits, write RURAL and give township) <b>St. Louis</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>5009 Mardel Ave.</b>		d. STREET ADDRESS (If rural, give location) <b>5009 Mardel Ave.</b>	
3. NAME OF DECEASED (Type or Print) a. (First) <b>JOHN</b> b. (Middle) c. (Last) <b>(KOLKOWSKI) KOLASKI</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>Oct. 29 1949</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>Nov. 14, 1875</b>
9. AGE (In years last birthday) <b>73</b>		IF UNDER 1 YEAR Months <b>11</b> Days <b>15</b>	IF UNDER 12 HRS. Hours <b>15</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unemployed 20 Years</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Poland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13a. FATHER'S NAME <b>Thomas Kolkowski</b>	
13b. MOTHER'S MAIDEN NAME <b>Josephine Unknown</b>		13c. NAME OF HUSBAND OR WIFE <b>Josephine Kolaski</b>	
14. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		15. SOCIAL SECURITY NO. <b>None</b>	
16. INFORMANT'S SIGNATURE OR NAME <b>Josephine Kolaski</b>		17. ADDRESS <b>5009 Mardel Ave.</b>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Cerebrovascular accident</b>  ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Hypertensive heart disease</b> <b>Diabetes mellitus</b> DUE TO (c) <b>arteriosclerosis generalis</b>  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21a. ACCIDENT SUICIDE HOMICIDE (Specify)	
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <b>97</b>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? <b>331X</b>		22. I hereby certify that I attended the deceased from <b>Jan, 1949</b> to <b>Oct, 1949</b> , that I last saw the deceased alive on <b>Oct 29, 1949</b> , and that death occurred at <b>10:00m.</b> , from the causes and on the date stated above.	
23a. SIGNATURE <b>Paul M. Parashik</b>		23b. ADDRESS <b>RD U 5203 Chippewa</b>	
23c. DATE SIGNED <b>10/31/49</b>		24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	
24b. DATE <b>Nov. 2, 1949</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>	
24d. LOCATION (City, town, or county) (State) <b>St. Louis, Mo.</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Kriegshauser</b>	
25. ADDRESS <b>4228 S. Kingshighway Bl</b>		DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE <b>Oct 31 1949</b>	

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by \_\_\_\_\_

..... Student Embalmer No. ....

working under my personal supervision.

Student .....  
Student Embalmer

Signed Richard W. Stovesund

Licensed Embalmer No. 4007

P. O. Address \_\_\_\_\_

**Note:** The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his **OWN HANDWRITING**. (Failure to comply with the above constitutes grounds for revocation of license.)

**If this body is not embalmed, fact should be so stated above.**