

FILED DEC 14 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

38625

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

318

1003

Registrar's No. 10383

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		Registrar's No. _____			
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived; if institution; residence before admission) a. STATE <u>Illinois</u> b. COUNTY <u>Madison</u>					
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>		c. LENGTH OF STAY (in this place) <u>17 days</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Madison</u>		d. STREET ADDRESS (If rural, give location) <u>911 Grand</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Anthony's Hoep.</u>				d. STREET ADDRESS (If rural, give location) <u>911 Grand</u>					
3. NAME OF DECEASED (Type or Print) a. (First) <u>Mary</u> b. (Middle) _____ c. (Last) <u>Danielewicz</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Dec 1 1949</u>						
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>March 30, 1887</u>			
9. AGE (In years last birthday) <u>62</u>		IF UNDER 1 YEAR Months <u>8</u> Days <u>1</u>		IF UNDER 4 HRS. Hours <u>1</u> Min. _____					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>			11. BIRTHPLACE (State or foreign country) <u>Poland</u>			
12. CITIZEN OF WHAT COUNTRY? <u>Poland</u>									
13a. FATHER'S NAME <u>Paul Karpowicz</u>			13b. MOTHER'S MAIDEN NAME <u>Unknown</u>			14. NAME OF HUSBAND OR WIFE <u>Stanley Danielewicz</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Stanley Danielewicz Madison, Ill.</u>					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)				MEDICAL CERTIFICATION					
<p>*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.</p>				I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Hemorrhage</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u>			
				ANTECEDENT CAUSES <u>Arteriosclerosis General</u>		DUE TO (b) _____			
				Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (c) _____			
II. OTHER SIGNIFICANT CONDITIONS <u>Passive Congestion on Lungs</u>				Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION <u>Nov 8 49</u>		19b. MAJOR FINDINGS OF OPERATION <u>Senile Cataract left eye</u>				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) <u>Madison Ill.</u>					
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>331X</u>					
22. I hereby certify that I attended the deceased from <u>Nov 23, 1949</u> to <u>Dec 1, 1949</u> , that I last saw the deceased alive on <u>Nov 1, 1949</u> and that death occurred at <u>10 A.M.</u> , from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title) <u>Robert E. Warner M.D.</u>				23b. ADDRESS <u>Paul Brown Bldg. 2nd St. 2-49</u>		23c. DATE SIGNED _____			
24a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Dec. 3, 1949</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Edwardsville Twp., Illinois</u>			
DATE REC'D BY LOCAL REG. <u>DEC 2 1949</u>		REGISTRAR'S SIGNATURE <u>J. B. Lasater</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Sedlack</u>		ADDRESS <u>Madison, Ill.</u>			

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

*John T. Sedlacek*

Licensed Embalmer No. *3747*

P. O. Address *Madison, Illinois*

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.