

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

39068

FILED NOV 21 1949

State File No. 9622

1003

9622

BIRTH NO. _____		REG. DIST. NO. <b>318</b>		PRIMARY REG. DIST. NO. _____		Registrar's No. _____			
1. PLACE OF DEATH a. COUNTY <b>St. Louis Mo</b>				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. LENGTH OF STAY (In this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) <b>St Louis</b>		OR TOWN _____			
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>1446 Chamber Str.</b>				d. STREET ADDRESS (If rural, give location) <b>1446 Chamber Str.</b>				_____	
3. NAME OF DECEASED (Type or Print)		a. (First) <b>Stanislaw</b>		b. (Middle) <b>(Stanley)</b>		c. (Last) <b>Michalak</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>11-6-49</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>May 8-1890</b>		9. AGE (In years last birthday) <b>59</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mill Worker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Box Factory</b>		11. BIRTHPLACE (State or foreign country) <b>Poland</b>		12. CITIZEN OF WHAT COUNTRY? _____			
13a. FATHER'S NAME <b>Stanley Michalak</b>			13b. MOTHER'S MAIDEN NAME <b>Rozalie</b>			14. NAME OF HUSBAND OR WIFE <b>Martha Michalak</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____		16. SOCIAL SECURITY NO. <b>494-24-8295</b>		17. INFORMANT'S SIGNATURE OR NAME <b>Mrs Martha Michalak</b>		ADDRESS <b>1446 Chamber</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, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Asthma - pulmonary edema</b> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Arteriosclerotic Card. Vasc. Dis</b> DUE TO (c) <b>Possible bronchiectasis</b> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.						INTERVAL BETWEEN ONSET AND 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>106</b>		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? <b>526X</b>		22. I hereby certify that I attended the deceased from <b>June 19, 1949</b> , to <b>Oct 19, 1949</b> , that I last saw the deceased alive on <b>31 Oct, 1949</b> , and that death occurred at <b>1:24 p.m.</b> , from the causes and on the date stated above.							
23a. SIGNATURE <b>Thomas H. Galt, M.D.</b>				23b. ADDRESS <b>St. Johns Hospital</b>		23c. DATE SIGNED <b>11/6/49</b>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>11-9-49</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>		24d. LOCATION (City, town, or county) (State) <b>St Louis Mo</b>			
DATE REC'D BY LOCAL REG. <b>NOV 8</b>		REGISTRAR'S SIGNATURE <b>J. H. ...</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Central Funeral Home</b>		ADDRESS <b>1841 Cass av</b>			

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

7 15 6  
3 1 2  
1 4 0  
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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 Me

Student Embalmer No. ....

working under my personal supervision.

Student .....  
Student Embalmer

Signed Elton R. Remelius

Licensed Embalmer No. 4283

P. O. Address St. Louis, Mo.

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.