

FILED DEC 27 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

42890

State File No.

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **10563**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St Louis Mo		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION 1618 Knapp Str.		d. STREET ADDRESS (If rural, give location) 26 1618 Knapp Str.	

3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
a. (First) Julia	b. (Middle)	c. (Last) Retkowska	(Month) (Day) (Year) 12-7-49
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow	8. DATE OF BIRTH Jan. 6 - 1879
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. 79
11. BIRTHPLACE (State or foreign country) Poland			12. CITIZEN OF WHAT COUNTRY?

13a. FATHER'S NAME Joseph Kowalski	13b. MOTHER'S MAIDEN NAME Katherine Jumba	14. NAME OF HUSBAND OR WIFE Michael Retkowski
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Miss Catherine Retkowski 1618 Knapp

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.	1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral thrombosis, left		INTERVAL BETWEEN ONSET AND DEATH
	2. ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arteriosclerosis and DUE TO (c) Chronic arteriosclerotic heart disease		
11. 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) 92
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? 332X

22. I hereby certify that I attended the deceased from **Sept. 23, 1949** to **Dec. 8, 1949**, that I last saw the deceased alive on **Dec. 8, 1949**, and that death occurred at **9 a. m.**, from the causes and on the date stated above.

23a. SIGNATURE Pherb. Paschuck	(Degree or title)	23b. ADDRESS 508 N. Grand	23c. DATE SIGNED 12/8/49
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 12-10-49	24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	24d. LOCATION (City, town, or county) (State) St Louis Mo

DATE REC'D BY LOCAL REG. DEC 8 1949	REGISTRAR'S SIGNATURE J. B. Foster	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Central Funeral Home 1841 Cass a
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

Dr.
R. P. Wilkinson

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 MR

Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed R. P. Wilkinson

Licensed Embalmer No. 3575

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.