

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 2701  
651

FILED JAN 28 1950

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY _____		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MISSOURI b. COUNTY 2144	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS		c. LENGTH OF STAY (in this place) 40 HRS	
d. FULL NAME OF HOSPITAL OR INSTITUTION 5400 WINONA ST.		d. STREET ADDRESS (If rural, give location) 5400 WINONA ST.	
3. NAME OF DECEASED (Type or Print) a. (First) PETER b. (Middle) — c. (Last) KOZLOWSKI.		4. DATE OF DEATH (Month) (Day) (Year) JAN. 20TH 1950	
5. SEX 0 MALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED	8. DATE OF BIRTH JULY 15TH 1874
9. AGE (in years last birthday) 75	IF UNDER 1 YEAR Months —	IF UNDER 1 YEAR Days —	IF UNDER 1 HRS. Hours — Min. —
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FORMER LABORER		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) POLAND. 4
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME UNKNOWN.	
13b. MOTHER'S MAIDEN NAME UNKNOWN		14. NAME OF HUSBAND OR WIFE UNKNOWN.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO.	16. SOCIAL SECURITY NO. NONE.	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Annette Carron 5400 Winona St.	
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, asthma, etc. - It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) cerebral hemorrhage ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) suppurated aged DUE TO (c) 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 none	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify) NO	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) 331X	
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?	
22. I hereby certify that I attended the deceased from 7-25-49 to 1-20-50, that I last saw the deceased alive on 1-20-50, and that death occurred at 7:30 A.M., from the causes and on the date stated above.			
23a. SIGNATURE C. C. Spitzer M.D.		23b. ADDRESS 4523 Skidley	23c. DATE SIGNED 1/20/50.
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE JAN. 23 1950	24c. NAME OF CEMETERY OR CREMATORY 50. CALVARY CEMETERY	24d. LOCATION (City, town, or county) (State) ST. LOUIS MO.
DATE REC'D BY LOCAL REG. JAN 21 1950	REGISTRAR'S SIGNATURE [Signature]	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Brockland and Co. 1827 HOGAN ST.	

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

*[Handwritten mark]*

**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 Guy W. Wilkinson

Licensed Embalmer No. 35754

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.