

FILED APR 25 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

15404

State File No. _____

BIRTH NO. _____ REG. DIST. NO. **317** PRIMARY REG. DIST. NO. **6076** Registrar's No. **947**

1. PLACE OF DEATH a. COUNTY St. Louis County		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY St. Louis	
b. CITY (If outside corporate limits, write RURAL and give township) Koch, Mo.		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis	
c. LENGTH OF STAY (In this place) 247 days		d. STREET ADDRESS (If rural, give location) 215 Sidney St.	
d. FULL NAME OF HOSPITAL OR INSTITUTION Robert Koch Hospital			

3. NAME OF DECEASED a. (First) Amelia		b. (Middle) Kaminiski		c. (Last) Kaminiski		4. DATE OF DEATH (Month) (Day) (Year) April 9 50	
5. SEX F	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed		8. DATE OF BIRTH 5-25-05		9. AGE (In years last birthday) IF UNDER 1 YEAR IF UNDER 2 HRS. 45	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nil		10b. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (State or foreign country) Poland		12. CITIZEN OF WHAT COUNTRY? ???	

13a. FATHER'S NAME John ??		13b. MOTHER'S MAIDEN NAME Anna ???		14. NAME OF HUSBAND OR WIFE Felix Kaminski deceased			
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) N		16. SOCIAL SECURITY NO. ???		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Francis Smith 1803 Delmar			
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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) Pulmonary Tuberculosis						INTERVAL BETWEEN ONSET AND DEATH 3 1/2 yrs	
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ 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 None		19b. MAJOR FINDINGS OF OPERATION 002X						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) None		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) ---		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) Koch Mo.	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) 4-9-50		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? ---	

22. I hereby certify that I attended the deceased from **8-5-49**, 19___, to **4-9-50**, 19___, that I last saw the deceased alive on **4-9-50**, 19___, and that death occurred at **1:45a m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Harold G. Suenk, M.D.		23b. ADDRESS Koch Mo.		23c. DATE SIGNED 4-9-50	
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 4/12/50		24c. NAME OF CEMETERY OR CREMATORY St. Matthews Cem.		24d. LOCATION (City, town, or county) (State) St. Louis, Mo.	
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DATE REC'D BY LOCAL REG. 4-11-50		REGISTRAR'S SIGNATURE Herbert R. Danks, M.D.		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Chulick Funeral Home 1722 S. Jefferson			
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

For

C. KOLICK

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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.....

Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed

Law M. Seymour

Licensed Embalmer No.

4343

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.