

FILED JUN 29 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 22157

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **5488**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <i>Mo</i> b. COUNTY	
b. CITY OR TOWN <i>St Louis Mo</i>		c. LENGTH OF STAY (in this place) <i>2 2 1/2</i>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <i>St Louis City Hospital</i>		d. STREET ADDRESS (If rural, give location) <i>1440 1/2 R. M. 10th St</i>	
3. NAME OF DECEASED a. (First) <i>Adam</i> b. (Middle) <i>S.</i> c. (Last) <i>Witkowski</i>		DATE OF DEATH (Month) (Day) (Year) <i>6. 23. 50</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <i>Single</i>	8. DATE OF BIRTH <i>June 15/1902</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>unemployed</i>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <i>48</i>
11. BIRTHPLACE (State or foreign country) <i>Poland</i>		12. CITIZEN OF WHAT COUNTRY? <i>4</i>	
13a. FATHER'S NAME <i>Adam Witkowski</i>		13b. MOTHER'S MAIDEN NAME <i>Bernice Urban</i>	
14. NAME OF HUSBAND OR WIFE		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. <i>498-03-3895</i>		17. INFORMANT'S SIGNATURE OR NAME <i>Bernice Witkowska</i> ADDRESS <i>1440 1/2 10th</i>	
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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>Lobar Pneumonia;</i> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <i>Gastric Hemorrhage</i> DUE TO (c) <i>caused by ruptured Varicose Veins</i>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input 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)	
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? <i>460X</i>			
22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <i>11:30 Am.</i> , from the causes and on the date stated above.			
23a. SIGNATURE <i>Joseph J. Sasser</i> (Degree or title) <i>Deputy Coroner</i>		23b. ADDRESS <i>1300 Claiborne</i>	
23c. DATE SIGNED <i>6/24/50</i>		24a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>	
24b. DATE <i>6/26/50</i>		24c. NAME OF CEMETERY OR CREMATORY <i>Cabary Cemetery</i>	
24d. LOCATION (City, town, or county) (State) <i>St Louis Mo</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>Central Funeral Home</i> ADDRESS <i>1841 Cass av</i>	
DATE REC'D BY LOCAL REG. <i>JUN 24 1950</i>		REGISTRAR'S SIGNATURE <i>J. B. Sasser</i>	

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 one

working under my personal supervision.

Student Embalmer No.

Signed William A. Dalton

Signed.....
Student Embalmer

Licensed Embalmer No. 1699

P. O. Address St. Charles

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.