

FILED OCT 10 1950

STANDARD CERTIFICATE OF DEATH

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 6076

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Illinois b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN JEFF. BRKS. MO.		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Scheller	
c. LENGTH OF STAY (in this place) 13 days		d. STREET ADDRESS RR #2	
d. FULL NAME OF HOSPITAL OR INSTITUTION VET. ADM. HOSP.			

3. NAME OF DECEASED a. (First) TONEY b. (Middle) c. (Last) MICHALSKI			4. DATE OF DEATH (Month) (Day) (Year) 9/30/50		
5. SEX M	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 6/2/86	9. AGE (In years last birthday) 64	10. IF UNDER 1 YEAR Months 9 Days 28
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Blacksmith		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Prairie Co., Ill.	12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME Marcell Michalski		13b. MOTHER'S MAIDEN NAME Josephine Stater		14. NAME OF HUSBAND OR WIFE Anna Michalski	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. World I 493-10-5871		17. INFORMANT'S SIGNATURE OR NAME ADDRESS V. A. HOSPITAL RECORDS	

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.		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) CARCINOMA ESOPHAGUS		INTERVAL BETWEEN ONSET AND DEATH 3 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.		150A	

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) None		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) 152X	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) V.A. 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 9/18, 1950, to 9/30, 1950, and that death occurred at 3:20p m., from the causes and on the date stated above.

23a. SIGNATURE Edward Kendall, M.D. (Degree or title)		23b. ADDRESS V.A. HOSP. JEFF. BRKS. MO.		23c. DATE SIGNED 10-1-50	
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE Oct 3/50		24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery		24d. LOCATION (City, town, or county) (State) St Louis Mo	
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DATE REC'D BY LOCAL REG. 10-2-50		REGISTRAR'S SIGNATURE [Signature]		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Central Funeral Home 1844 Cass	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

50 7 50  
86 6 2  
11 3 28

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.....

.....  
working under my personal supervision.

Student Embalmer No.....

Signed.....

*Robert M Murray*

Signed.....

Student Embalmer

Licensed Embalmer No. 3749

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.