

No. 300
10. 48

FILED DEC 28 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 43216
Registrar's No. 2090

BIRTH NO. _____ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 6076

1. PLACE OF DEATH a. COUNTY Rural Wallowa		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Ill COUNTY East St. Louis	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis County		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN EAST ST. LOUIS 8120	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Vincente Sanitarium		d. STREET ADDRESS (If rural, give location) 7301 St. Charles Rock Road	
3. NAME OF DECEASED (Type or Print) ANNA		4. DATE OF DEATH (Month) (Day) (Year) 12 20 50	
5. SEX F	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH March 20 1902
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Own Grocery Store		9b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 48
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Own Grocery Store		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Excelsior, Penna.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME Peter Kwiatkowski	
13b. MOTHER'S MAIDEN NAME UNKNOWN		14. NAME OF HUSBAND OR WIFE Charles Masulas	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. - -	
17. INFORMANT'S SIGNATURE OR NAME Marie Gaymark		18. ADDRESS 2054 14th St. & G	
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) Meningitis, cerebrospinal (non-specific) ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Cachexia of liver 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	
20. AUTOPSY? YES <input checked="" 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) 2570	
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 12/6, 1950, to 12/20, 1950, that I last saw the deceased alive on 12/19, 1950, and that death occurred at 1:55 p.m., from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) Joseph A. Costello, M.D.		23b. ADDRESS 2407 N. Burg, St. Louis 6	
23c. DATE SIGNED 12/20/50		24a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	
24b. DATE 12-21-50		24c. NAME OF CEMETERY OR CREMATORY	
24d. LOCATION (City, town, or county) (State) EAST ST. LOUIS ILL.		DATE REC'D BY LOCAL REG. 12/21/50	
REGISTRAR'S SIGNATURE Herbert Robinson, M.D.		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Harry Robins East St. Louis, Ill.	

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

40000

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 Frank Prohoff

Signed.....

Student Embalmer

Licensed Embalmer No. 4356

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.