

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No. **21284**
5405

BIRTH NO. **99926-51** REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. _____

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

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo b. COUNTY		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St Louis Mo		c. LENGTH OF STAY (in this place) 12 H	c. CITY (if outside corporate limits, write RURAL and give township) OR TOWN St Louis		2069
d. FULL NAME OF HOSPITAL OR INSTITUTION ST LUKES HOSP			e. STREET ADDRESS (If rural, give location) 5124 Palm St		
3. NAME OF DECEASED (Type or Print) a. (First) Infant b. (Middle) c. (Last) Karpowicz			4. DATE OF DEATH (Month) (Day) (Year) 6 12 - 51		
5. SEX F	6. COLOR OR RACE Wh	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH 6-12-51	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months Days
				12	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) ST. LOUIS	
12. CITIZEN OF WHAT COUNTRY?					
13a. FATHER'S NAME Anthony		13b. MOTHER'S MAIDEN NAME Elizabeth Czarnacki		13c. 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.	17. INFORMANT'S SIGNATURE OR NAME Anthony Karpowicz		
			ADDRESS 5724 Palm		
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*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>		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) atelectasis ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Prematurity DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			INTERVAL BETWEEN ONSET AND DEATH
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) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 762.5	
22. I hereby certify that I attended the deceased from 6/12 1951 , to 6/12 1951 , that I last saw the deceased alive on 6/12 1951 , and that death occurred at 10:29 m., from the causes and on the date stated above.					
23a. SIGNATURE W. D. Lawler, M.D.			(Degree or title)	23b. ADDRESS 1161 Campbell Village Blvd	23c. DATE SIGNED 6/13/51
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE 6-14-51	24c. NAME OF CEMETERY OR CREMATORY Calvary		24d. LOCATION (City, town, or county) (State) St Louis Mo
DATE REC'D BY LOCAL JUN 13 1951		REGISTRAR'S SIGNATURE J. B. Laster		25. FUNERAL DIRECTOR'S SIGNATURE St Louis Funeral Home	
				ADDRESS	

2205 51 Louis mo

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.....

No Embalming

Signed.....

Signed.....
Student Embalmer

Licensed Embalmer No.....

P. O. Address.....

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.

CT 5895