

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

25084

FILED JUL 26 1951

State File No. 6050

318

1003

BIRTH NO.		REG. DIST. NO. 318		PRIMARY REG. DIST. NO.		Registrar's No.	
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>		c. LENGTH OF STAY (in this place)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>		2079	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>4648 Farlin Ave</b>				7. d. STREET ADDRESS (If rural, give location) <b>4648 Farlin Ave</b>			
3. NAME OF DECEASED (Type or Print) a. (First) <b>Margaret</b>		b. (Middle) <b>J. Nowakowsky</b>		c. (Last)		4. DATE OF DEATH (Month) (Day) (Year) <b>July 4 1951</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>		8. DATE OF BIRTH <b>February 15 1902</b>	
9. AGE (in years last birthday) <b>49</b>		IF UNDER 1 YEAR Months		IF UNDER 24 HRS. Days		IF UNDER 24 HRS. Hours	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Norway</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13a. FATHER'S NAME <b>Carl Jensen</b>		13b. MOTHER'S MAIDEN NAME <b>Lena (Unknown)</b>		14. NAME OF HUSBAND OR WIFE <b>John I. Nowakowsky</b>			
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 ADDRESS <b>John I. Nowakowsky 4648 Farlin Ave</b>			
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, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>BRONCHIAL ASTHMA</b>  ANTECEDENT CAUSES Morbidity 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.				INTERVAL BETWEEN ONSET AND DEATH <b>24RS.</b>	
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? <b>24/1X</b>			
22. I hereby certify that I attended the deceased from <b>Sept</b> , 1949, to <b>July 4</b> , 1951, that I last saw the deceased alive on <b>July 3</b> , 1951, and that death occurred at <b>6:15 p. m.</b> , from the causes and on the date stated above.							
23a. SIGNATURE <b>Thomas W. Parker</b>				0 (Degree or title) <b>m. p.</b>		23b. ADDRESS <b>4660 Maryland</b>	
23c. DATE SIGNED <b>7/6/51</b>		24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>July 7 1951</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Oak Grove Cemetery</b>	
24d. LOCATION (City, town, or county) (State) <b>St. Louis Co Mo</b>		DATE REC'D BY LOCAL REG. <b>JUL 6 1951</b>		REGISTRAR'S SIGNATURE <b>J. B. Farlin</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Calvin F. Futz 4828 Nat. Bridge Blvd</b>	

(Licensed Embalmer's Statement on Reverse Side)

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

*Emb separate cert filed*

1951

9-7-51

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.....

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.