No. 300
10.48

FILED JUL 28 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 25412

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 6362

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Louis, Mo
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 5445 Wren Ave.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Mo.
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Louis 2079
d. STREET ADDRESS (If rural, give location): 5445 Wren Ave.

3. NAME OF DECEASED (Type or Print): a. (First) Henry b. (Middle) c. (Last) Truszka
4. DATE OF DEATH (Month) (Day) (Year): 7-14-51
5. SEX: M
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: 1-19-1875
9. AGE (In years last birthday): 76 — If under 1 year: Months, Days — If under 1 hr.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Austria
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME: Mathew Truszka
13b. MOTHER'S MAIDEN NAME: Julia Jaskiewicz
14. NAME OF HUSBAND OR WIFE: Josephine
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 355-10-5928
17. INFORMANT'S SIGNATURE OR NAME: Alex Truszka — ADDRESS: 5445 Wren Av.

MEDICAL CERTIFICATION

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.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 5 days

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Acute Prostatitis — 2 weeks

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 ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify): No
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 ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7/10, 1951, *to* 7/14, 1951, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* 10-P *m., from the causes and on the date stated above.*

23a. SIGNATURE: G. F. Chopan (Degree or title)
23b. ADDRESS: 5744 Clemens
23c. DATE SIGNED: 7/17/51

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 7-18-51
24c. NAME OF CEMETERY OR CREMATORY: Calvary
24d. LOCATION (City, town, or county) (State): St. Louis, Mo

DATE REC'D BY LOCAL REGISTRAR: JUL 17 1951
REGISTRAR'S SIGNATURE: J. B. Forster

25. FUNERAL DIRECTOR'S SIGNATURE: St. Louis Funeral Home — ADDRESS: 2205 St. Louis

(Licensed Embalmer's Statement on Reverse Side)

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

W.L. Chapin 5744 Clemens

Pho. DC 8085

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~~ me

Student Embalmer No. .....

working under my personal supervision.

Student .....
Student Embalmer

Signed [signature]

Licensed Embalmer No. 4699

P. O. Address St Charles, Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.