

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

35641

State File No.

FILED OCT 23 1951

REG. DIST. NO. 318

PRIMARY REG. DIST. NO. 1003

Registrar's No. 8679

BIRTH NO. _____

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

c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS 2149

d. FULL NAME OF HOSPITAL OR INSTITUTION 5304 BANCROFT

11. STREET ADDRESS (If rural, give location) 5304 BANCROFT

3. NAME OF DECEASED (Type or Print)
a. (First) THOMAS
b. (Middle) MATT
c. (Last) STANEK

4. DATE OF DEATH (Month) (Day) (Year) SEPT-30-51

5. SEX M

6. COLOR OR RACE W.

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) M

8. DATE OF BIRTH JUNE-22-1904

9. AGE (In years last birthday) 47 YRS
If under 1 year: Months _____ Days _____
If under 14 hrs: Hours _____ Min. _____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BARTENDER

10b. KIND OF BUSINESS OR INDUSTRY _____

11. BIRTHPLACE (State or foreign country) MONTGOMERY MINN.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME MATT STANEK

13b. MOTHER'S MAIDEN NAME ANNA Budion

14. NAME OF HUSBAND OR WIFE RAMONA M. STANEK

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO

16. SOCIAL SECURITY NO. 493-07-7717

17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs Ramona M. Stanek 5304 Bancroft

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, ashenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial Infarction

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Coronary arteriosclerotic Heart Disease
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 6 hrs

19a. DATE OF OPERATION _____

19b. MAJOR FINDINGS OF OPERATION _____

20. AUTOPSY? YES NO

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 NOT WHILE AT WORK

21f. HOW DID INJURY OCCUR? 4201

22. I hereby certify that I attended the deceased from Feb. 21, 1951, to Sept. 30, 1951, that I last saw the deceased alive on Sept. 30, 1951, and that death occurred at Silla, from the causes and on the date stated above.

23a. SIGNATURE M. E. Mueller (Degree or title) M.D.

23b. ADDRESS 634 N. Grand Blvd.

23c. DATE SIGNED 10-1-51

24a. BURIAL CREMATION, REMOVAL (Specify) Removal

24b. DATE Oct 2-51

24c. NAME OF CEMETERY OR CREMATORY _____

24d. LOCATION (City, town, or county) (State) MINNEAPOLIS MINN

DATE REC'D BY LOCAL REG. OCT 1 1951

REGISTRAR'S SIGNATURE Earl Smith

25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS E. J. Schuur 3125 Lafayette Ave

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

300
46

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 Joseph B. Vollmer

Licensed Embalmer No. 4014

P. O. Address 3125 Lafayette

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

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