

FILED FEB 1 1953

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

943

State File No.

BIRTH NO. _____ REG. DIST. NO. 116 PRIMARY REG. DIST. NO. 3020 Registrar's No. 26

362

1. PLACE OF DEATH a. COUNTY FRANKLIN		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo. b. COUNTY FRANKLIN	
b. CITY (If outside corporate limits, write RURAL and give township) Washington		c. CITY (If outside corporate limits, write RURAL and give township) 0362	
c. LENGTH OF STAY (In this place) 10Yr.		d. STREET ADDRESS (If rural, give location) WASHINGTON Mo.	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. FRANCIS			

3. NAME OF DECEASED (Type or Print) ANTONI			b. (Middle) STEPNOWSKI		c. (Last)		4. DATE OF DEATH (Month) (Day) (Year) JAN. 24 1953						
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED		8. DATE OF BIRTH Feb. 21 1879		9. AGE (In years last birthday) 73		if UNDER 1 YEAR Months 11	if UNDER 24 HRS. Days 3	if UNDER 1 MIN. Hours 	if UNDER 1 MIN. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor				10b. KIND OF BUSINESS OR INDUSTRY Labor		11. BIRTHPLACE (City and State or Foreign Country) POLAND			12. CITIZEN OF WHAT COUNTRY? 4				

13a. FATHER'S NAME MIKEL STEPNOWSKI		13b. MOTHER'S MAIDEN NAME UNKNOWN		14. 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) NONE		16. SOCIAL SECURITY NO. NONE		17. INFORMANT'S SIGNATURE OR NAME Mrs. JULIA TOBIASZ	
				ADDRESS St. LOUIS	

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>		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Medical Certification Lobar 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. 490x			
		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.			

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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) (Min.)		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 Jan 20 to 1:56, 1953, that I last saw the deceased alive on 1:25 1953, and that death occurred at 9:30 a.m., from the causes and on the date stated above.

23a. SIGNATURE Mr. Henry		(Degree or title)		23b. ADDRESS Union Mo		23c. DATE SIGNED 1-26-53	
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24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24b. DATE Jan. 27 1953		24c. NAME OF CEMETERY OR CREMATORY St. ANTHONY CEM.		24d. LOCATION (City, town, or county) (State) SULLIVAN FRANKLIN MO.	
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DATE REC'D BY LOCAL REG. Jan. 26, 1953		REGISTRAR'S SIGNATURE W.P. Hedeman		99		25. FUNERAL DIRECTOR'S SIGNATURE Rev. P. Stepper		ADDRESS Sullivan, Mo.	
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(Licensed Embalmer's Statement on Reverse Side)

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

FEB 2 1953

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

Paul F. Knollenberg Student Embalmer No. 2631

working under my personal supervision.

Student
Student Embalmer

Signed

Paul F. Knollenberg

Licensed Embalmer No. 2631

P. O. Address Sullivan, Me

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.