

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED JAN 28 1953

318

1003

State File No. 3503

Registrar's No. 0217

BIRTH NO. _____		REG. DIST. NO. _____		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, Mo.</b>		c. LENGTH OF STAY (in this place) <b>60 yrs</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>		<b>2019</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Alexian Brothers Hospital</b>				d. STREET ADDRESS (If rural, give location) <b>415 Iron St.</b>			
3. NAME OF DECEASED (Type or Print) a. (First) <b>PAUL</b> b. (Middle) <b>O</b> c. (Last) <b>MICHALSKI</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>January 7, 1953</b>				
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>married</b>	8. DATE OF BIRTH <b>Sept. 28, 1885</b>		9. AGE (In years last birthday) <b>67</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>installer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Public Utility</b>		11. BIRTHPLACE (City and State or Foreign Country) <b>Moniteau County, Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13a. FATHER'S NAME <b>WILLIAM ANDREW MICHALSKI</b>		13b. MOTHER'S MAIDEN NAME <b>EMILIE KLATT</b>		14. NAME OF HUSBAND OR WIFE <b>SOPHIE VOGES</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>yes Phillipine War</b>		16. SOCIAL SECURITY NO. <b>493-05-1785A</b>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Mrs. Sophie Michalski, 415 Iron St.</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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Lobular Pneumonia</b>  ANTECEDENT CAUSES <i>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</i> DUE TO (b) <b>Debrite Phlebitis</b>  DUE TO (c) _____  II. OTHER SIGNIFICANT CONDITIONS <i>Conditions contributing to the death but not related to the disease or condition causing death.</i>					INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b>  <b>1 yr</b>	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <b>Lobular Pneumonia - solitary, kidneys</b>						20. AUTOPSY? YES <input checked="" 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? <b>260X</b>				
22. I hereby certify that I attended the deceased from <b>Apr</b> , 19 <b>51</b> , to <b>Jan</b> , 19 <b>53</b> , that I last saw the deceased alive on <b>1/6</b> , 19 <b>53</b> , and that death occurred at <b>8:00 Am.</b> , from the causes and on the date stated above.							
23a. SIGNATURE <b>Dr. Robert M. O.</b> (Degree or title)				23b. ADDRESS <b>5600 P. Compton</b>		23c. DATE SIGNED <b>1/8/52</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>removal</b>	24b. DATE <b>Jan. 10, 1953</b>	24c. NAME OF CEMETERY OR CREMATORY <b>St. Trinity Cemetery</b>		24d. LOCATION (City, town, or county) (State) <b>St. Louis County, Mo.</b>			
DATE REC'D BY LOCAL REG. <b>JAN 9 1953</b>		REGISTRAR'S SIGNATURE <b>Charles Smith MO</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Beiderwieden F.H.Inc., 1936 St. Louis Ave.</b>			

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

Dr. Gerard A. Nester  
5600 S. Compton Ave.,  
2 -4 P. M. except Wednesday

**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 Max L. Clarke

Licensed Embalmer No. 4170

P. O. Address St Louis Mo.

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.