

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **15562**  
Registrar's No. **3805**

FILED APR 23 1953

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Illinois</b> b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>		c. CITY OR TOWN <b>West Frankfort</b>	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (In this place) <b>2 days</b>		e. STREET ADDRESS (If rural, give location) <b>Rural Route #1.</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>St. Luke's Hosp.</b>			
3. NAME OF DECEASED (Type or Print) <b>Chester</b>		a. (First) <b>Chester</b>	b. (Middle)
		c. (Last) <b>Chrostoski</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>4-1-53</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>6-7-1907</b>
9. AGE (In years last birthday) <b>45</b>		IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>coal miner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>coal</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>Ohio</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13a. FATHER'S NAME <b>Alex Chrostoski</b>		13b. MOTHER'S MAIDEN NAME <b>unknown</b>	14. NAME OF HUSBAND OR WIFE <b>Wanda Chrostoski</b>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>356-01-1256</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Wanda Chrostoski, R.R. #1</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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Histoplasmosis</b>  INTERVAL BETWEEN ONSET AND DEATH <b>6 wks</b>  ANTECEDENT CAUSES DUE TO (b) _____ DUE TO (c) _____  Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.  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 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>1342</b>			
22. I hereby certify that I attended the deceased from <b>3/1</b> , 19 <b>53</b> , to <b>4/1</b> , 19 <b>53</b> , that I last saw the deceased alive on <b>4/1</b> , 19 <b>53</b> and that death occurred at <b>2:00</b> m., from the causes and on the date stated above.			
23a. SIGNATURE <b>Paul O. Hagemann MD</b> (Degree or title)		23b. ADDRESS <b>3720 Washington</b>	
23c. DATE SIGNED <b>4/10/53</b>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>removal</b>		24b. DATE <b>4-2-53</b>	
24c. NAME OF CEMETERY OR CREMATORY		24d. LOCATION (City, town, or county) (State) <b>West Frankfort, Ill</b>	
DATE REC'D BY LOCAL REG. <b>APR 11 1953</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>W. C. Smith MD</b> ADDRESS <b>Union F.H., West Frankfort, Ill</b>	

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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.....  
Signature of Student Embalmer

Signed.....

Licensed Embalmer No. 4063

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

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