

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **37641**
Registrar's No. **9908**

FILED OCT 29 1953

REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St Louis Mo		c. CITY OR TOWN St Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION: 1609 Knapp Str.		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or Print) Kazimier z (Casimir) Szywalski		4. DATE OF DEATH (Month) 10 (Day) 16 (Year) 53	
5. SEX M	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH feb 22- 1896
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY St. Louis County Water Dept.	11. BIRTHPLACE (City and State or Foreign Country) Poland
13a. FATHER'S NAME C Szywalski		13b. MOTHER'S MAIDEN NAME Unknown	
14. NAME OF HUSBAND OR WIFE Deceased		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. 492-09-6780		17. INFORMANT'S SIGNATURE OR NAME Mrs Mary Breece ADDRESS 1609 Knapp	
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.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Brain tumor INTERVAL BETWEEN ONSET AND DEATH 8 mos ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. 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 2/5/53		19b. MAJOR FINDINGS OF OPERATION Brain tumor - meningioma - metastatic	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21a. ACCIDENT (Specify) SUICIDE HOMICIDE	
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? 193X		22. I hereby certify that I attended the deceased from 1/30 , 19 53 , to 2/19 , 19 53 , that I last saw the deceased alive on 2/19 , 19 53 , and that death occurred at 7:30 p.m. , from the causes and on the date stated above.	
23a. SIGNATURE B. A. Smith M.D. (Degree or title)		23b. ADDRESS Beaumont Med. Bldg	
23c. DATE SIGNED 10/16/53		24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
24b. DATE 10-19-53		24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	
24d. LOCATION (City, town, or county) (State) St Louis Mo		25. FUNERAL DIRECTOR'S SIGNATURE Earl Smith M.D. ADDRESS Central Funeral Home 1841 Cass	
DATE REC'D BY LOCAL REG. OCT 17 1953		REGISTRAR'S SIGNATURE Earl Smith M.D.	

(Licensed Embalmer's Statement on Reverse Side)

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

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 *G. W. Wilkinson*

Licensed Embalmer No. *357*

P. O. Address *W. Low*

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.