No. 300
10.48

STANDARD CERTIFICATE OF DEATH

State File No. 9916

BIRTH No. FILED MAR 19 1954 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 2318

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St Louis
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Park Lane

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Mo
b. COUNTY: 2079
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St Louis
d. STREET ADDRESS (If rural, give location): 5958 Lalite

3. NAME OF DECEASED (Type or Print): a. (First) Mary b. (Middle) c. (Last) Brys

4. DATE OF DEATH (Month) 3 (Day) 9 (Year) 54

5. SEX F **6. COLOR OR RACE** W **7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED** (Specify) W **8. DATE OF BIRTH** 1883 **9. AGE** (In years last birthday) 71 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): Houses wife
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Poland
12. CITIZEN OF WHAT COUNTRY? 4

13a. FATHER'S NAME Joseph
13b. MOTHER'S MAIDEN NAME Marcela Szymanski
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)
16. SOCIAL SECURITY NO.
17. INFORMANT'S SIGNATURE OR NAME Leo Brys **ADDRESS** 5958 Lalite

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) Cerebral apoplexy — INTERVAL BETWEEN ONSET AND DEATH: 1 Day

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Hypertensive cardiac disease — 6 months
DUE TO (c) Hyper-thyroidism — 6 months

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.* aneurism of aorta — 6 months

19a. DATE OF OPERATION 3/8/54
19b. MAJOR FINDINGS OF OPERATION Thyrotoxicosis. Toxic thyroid adenoma
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) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

2521

22. *I hereby certify that I attended the deceased from* _____, 19__, *to* March 9, 1954, *that I last saw the deceased alive on* March 9, 1954, *and that death occurred at* 10A m., *from the causes and on the date stated above.*

23a. SIGNATURE Henry E Rosenberg (Degree or title) MD
23b. ADDRESS 1467 N. Union
23c. DATE SIGNED 3/10/54

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 3-13-54
24c. NAME OF CEMETERY OR CREMATORY Calvary
24d. LOCATION (City, town, or county) St Louis (State) Mo

DATE REC'D BY LOCAL REG. MAR 19 1954
REGISTRAR'S SIGNATURE J Carl Smith MD
FUNERAL DIRECTOR'S SIGNATURE St Louis Funeral Home **ADDRESS** 2205 St Louis Ave
(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 Me

....., Student Embalmer No. .....,

working under my personal supervision.

Student .....
Student Embalmer

Signed G W Wilkinson

Licensed Embalmer No. 3575

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.