

FILED JUL 26 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 25057
Registrar's No. 5935

BIRTH NO. _____ 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). a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Mo.		c. CITY OR TOWN St. Louis	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) 7 days		e. STREET ADDRESS (If rural, give location) 26 1525 North 17th St. 22690	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. John's Hospital			

3. NAME OF DECEASED (Type or Print) John F. Panus a. (First) b. (Middle) c. (Last)			4. DATE OF DEATH (Month) (Day) (Year) June 29, 1954		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Jan. 6, 1892	9. AGE (In years last birthday) 62	10. UNDER 1 YEAR 5 Months 23 Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Delmar Realty	11. BIRTHPLACE (City and State or Foreign Country) Poland	12. CITIZEN OF WHAT COUNTRY? USA	

13a. FATHER'S NAME John Panus	13b. MOTHER'S MAIDEN NAME Frances	14. NAME OF HUSBAND OR WIFE Eleanor Linowski Panus
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY (If res. give war or dates of service) 488-09-2509	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Eleanor Panus (wife) 1525 N. 17th St

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.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral thrombosis		INTERVAL BETWEEN ONSET AND DEATH 2 days
	ANTECEDENT CAUSES DUE TO (b) Arterio sclerotic cere- DUE TO (c) chronic disease		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Diabetes mellitus		

19a. DATE OF OPERATION None	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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? 331X
22. I hereby certify that I attended the deceased from 12 June, 1954, to 29 June, 1954, that I last saw the deceased alive on 29 June, 1954, and that death occurred at 6:30 p.m., from the causes and on the date stated above.		

23a. SIGNATURE W. J. P. [Signature]	23b. ADDRESS 6000 W. Harrison	23c. DATE SIGNED 30 June 1954
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 7/2/54	24c. NAME OF CEMETERY OR CREMATORY Calvary
		24d. LOCATION (City, town, or county) (State) St. Louis, Mo.

DATE REC'D BY LOCAL REG. JUL 1 1954	REGISTRAR'S SIGNATURE J. Earl Smith, M.D.	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS St. Louis Funeral Home 2205 St. Louis
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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..... *Edward G. Lehmann*

Licensed Embalmer No. *456*

P. O. Address *St. Louis*

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.