

FILED JUL 26 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 25425

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 5844

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo b. COUNTY				
b. CITY (If outside corporate limits, write RURAL and give town) ST. LOUIS		c. LENGTH OF STAY (In this place)		c. CITY OR TOWN St Louis		
d. FULL NAME OF HOSPITAL OR INSTITUTION ST. LOUIS CITY HOSPITAL		e. STREET ADDRESS 1449a Cass ave		226 1/2		
3. NAME OF DECEASED (Type or Print) a. (First) JULIUS		b. (Middle)		c. (Last) WIECZOREK		
4. DATE OF DEATH (Month) (Day) (Year) JUNE 28 1954		5. SEX Male		6. COLOR OR RACE White		
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH Oct 18- 81		9. AGE (In years last birthday) 72		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sterling Alumiman		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) Poland		
13a. FATHER'S NAME Unknown		13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE Maryann		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY 487-22-6343		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Maryann Wieczorek 1449 Cass av		
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) MYOCARDIAL INFARCTION. ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) CARCINOMA OF STOMACH, Metastatic DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS. Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		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)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 151 X		
22. I hereby certify that I attended the deceased from 4-18-54, 19___, to 6-28-54, 19___, that I last saw the deceased alive on 6-28-54, 19___, and that death occurred at 1:15A m., from the causes and on the date stated above.						
23a. SIGNATURE H.S. Knatta M.D.		(Degree or title)		23b. ADDRESS 1515 Lafayette Avenue		
23c. DATE SIGNED 6-28-54		24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 7/1/54		
24c. NAME OF CEMETERY OR CREMATORY Mt Olive Cemetery		24d. LOCATION (City, town, or county) St. Louis County		(State)		
DATE REC'D BY LOCAL REG. JUN 29 1954		REGISTRAR'S SIGNATURE J. Carl Smith M.D.		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Central Funeral Home 1841 Cass		

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

(Licensed Embalmer's Statement on Reverse Side)

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 *John W. Rister*.....
Licensed Embalmer No. *3980*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.**