

FILED AUG 11 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **25687**
Registrar's No. **1814**

BIRTH NO. **58359-54** REG. DIST. NO. **317** PRIMARY REG. DIST. NO. **547**

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo b. COUNTY	
b. CITY St. Louis OR TOWN		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Mary Hospital		d. STREET ADDRESS (If rural, give location) 2200a Sullivan ave	

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH		
a. (First) Infant	b. (Middle) Studnicki	c. (Last)	(Month) 7	(Day) 25	(Year) 54

5. SEX M	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED 0	8. DATE OF BIRTH 7-24-54	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	IF UNDER 12 HRS. Days	IF UNDER 14 HRS. Hours	IF UNDER 14 HRS. Min.
							24	

10a. USUAL OCCUPATION (Give kind of work done during week ending 10 days prior if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY
NONE	NONE	St Louis Mo	U.S.A

13a. FATHER'S NAME Fredrick A. Studnicki	13b. MOTHER'S MAIDEN NAME Darlene LaChance	14. NAME OF HUSBAND OR WIFE ***** NONE
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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. NONE	17. INFORMANT'S SIGNATURE OR NAME Fredrick Studnicki	ADDRESS 2200a Sullivan
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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.	1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Atelectasis		INTERVAL BETWEEN ONSET AND DEATH 2 1/2 hrs
	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	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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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)
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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?
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22. I hereby certify that I attended the deceased from **7/24**, 19**54**, to **7/25**, 19**54**, that I last saw the deceased alive on **7/25**, 19**54**, and that death occurred at **7:05** a.m., from the causes and on the date stated above.

23a. SIGNATURE Jackson G...	(Degree or title) MD	23b. ADDRESS 634 No. Grane	23c. DATE SIGNED 7/26/54
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24a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	24b. DATE 7-26-54	24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	24d. LOCATION (City, town, or county) (State) St Louis Mo.
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DATE REC'D BY LOCAL REG 7/26/54	REGISTRAR'S SIGNATURE Walter R. Lamborn	25. FUNERAL DIRECTOR'S SIGNATURE Central Funeral Home	ADDRESS 1841 Cass av
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(Licensed Embalmer's Statement on Reverse Side)

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

Dr. Jackson Eto
623
Mo Theater Bldg
11. A.M.

✓ 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
Student Embalmer

Signed.....

Licensed Embalmer No.....

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