

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

35587

State File No. ....

8814

FILED OCT. 26 1954

BIRTH NO. _____		REG. DIST. NO. <b>318</b>		PRIMARY REG. DIST. NO. <b>1003</b>		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give OR TOWN <b>ST. LOUIS</b> )		c. LENGTH OF STAY (In this place) _____		c. CITY OR TOWN <b>St. Louis</b>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>ST. LOUIS CITY HOSPITAL</b>				e. STREET ADDRESS (If rural, give location) <b>24 2857a Missouri</b>		224%	
3. NAME OF DECEASED (Type or Print) a. (First) <b>MICHAEL</b>			b. (Middle) _____			c. (Last) <b>KOSTELNIK</b>	
4. DATE OF DEATH (Month) (Day) (Year) <b>SEPT. 26 1954</b>		5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Single</b>	
8. DATE OF BIRTH <b>Oct. 21-1887</b>		9. AGE (In years last birthday) <b>66</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		11. BIRTHPLACE (City and State or Foreign Country) <b>Austria</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		12. CITIZEN OF WHAT COUNTRY? <b>Austria</b>		12. CITIZEN OF WHAT COUNTRY? _____	
13a. FATHER'S NAME <b>Michael Kostelnik</b>			13b. MOTHER'S MAIDEN NAME <b>Ethel Pastor</b>			14. NAME OF HUSBAND OR WIFE <b>None</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>No</b>		17. INFORMANT'S SIGNATURE OR NAME <b>Veronica McClure</b> ADDRESS <b>2857a Missouri</b>			
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) <b>Uremia &amp; Toxicity due tissue anoxia</b> ANTECEDENT CAUSES DUE TO (b) <b>Urinary Extravasation SQ</b> DUE TO (c) <b>Rupture Posterior Uvula</b> Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. 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? <b>603X</b>					
22. I hereby certify that I attended the deceased from <b>9-24-54</b> , 19____, to <b>9-26-54</b> , 19____, that I last saw the deceased alive on <b>9-26-54</b> , 19____, and that death occurred at <b>10:45A.m.</b> , from the causes and on the date stated above.							
23a. SIGNATURE <b>U.A. Kovalin M.D.</b> (Degree or title) _____				23b. ADDRESS <b>1515 Lafayette Avenue</b>		23c. DATE SIGNED <b>9-27-54</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		24b. DATE <b>9-29-1954</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Resurrection Cemetery</b>		24d. LOCATION (City, town, or county) (State) <b>St. Louis Co., Mo.</b>	
DATE REC'D BY LOCAL REG. <b>SEP. 28 1954</b>		REGISTRAR'S SIGNATURE <b>J. Carl Smith, M.D.</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Witt Bros, 2929 S. Jefferson</b> ADDRESS _____			

S.O. (Licensed Embalmer's Statement on Reverse Side)

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

No. 800  
10. 48

**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.....  
*Harold C. Witt*

Licensed Embalmer No. *435*

P. O. Address *2929 S. J*

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.