

FILED OCT 26 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **35830**
Registrar's No. **8588**

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		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 23 615 Walnut		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or Print) a. (First) STANLEY b. (Middle) LOUIS c. (Last) PIOTROWSKI			4. DATE OF DEATH (Month) (Day) (Year) SEPTEMBER 19, 1954		
5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	
8. DATE OF BIRTH Sept 18 1884		9. AGE (In years last birthday) 70		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown	
10a. USUAL OCCUPATION		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) Poland	
12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME Unknown Piotrowski		13b. MOTHER'S MAIDEN NAME Unknown	
14. NAME OF HUSBAND OR WIFE Helen Piotrowski		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 Helen Moore		ADDRESS 10660 St. Augustine			

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i>		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Brain stem infarction-haemorrhage		ANTECEDENT CAUSES DUE TO (b) Arteriosclerosis			
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 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? 331A	

22. I hereby certify that I attended the deceased from **9-16-54**, 19____, to **9-19-54**, 19____, that I last saw the deceased alive on **9-19-54**, 19____, and that death occurred at **8:15A** m., from the causes and on the date stated above.

23a. SIGNATURE William R. Boniface, M.D.		(Degree or title)		23b. ADDRESS 1515 Lafayette Avenue	
23c. DATE SIGNED 9-20-54		24a. BURIAL, CREMATION, REMOVAL Removal		24b. DATE Sep 21 54	
24c. NAME OF CEMETERY OR CREMATORY Sun Set Burial Park		24d. LOCATION (City, town, or county) (State) St. Louis Cty Mo			
DATE REC'D BY LOCAL REG. SEP 20 1954		REGISTRAR'S SIGNATURE J. Carl Smith mo		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS E. J. Schnur 3125 Lafayette	

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..... *John B. Ballmer*

Licensed Embalmer No. *4015*

P. O. Address *3125 S. Dupuy*

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.