

FILED NOV 22 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 38624

BIRTH NO. _____		REG. DIST. NO. <b>318</b>		PRIMARY REG. DIST. NO. <b>1003</b>		Registrar's No. <b>9881</b>	
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 township) OR TOWN <b>St Louis</b>		c. LENGTH OF STAY (In this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St Louis</b>		d. STREET ADDRESS (If rural, give location) <b>15 4516 Oregon Av</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>De Paul Hospital</b>				3. NAME OF DECEASED a. (First) <b>Agnes</b> (Type or Print)			
b. (Middle) <b>M</b>		c. (Last) <b>Bielicki Chott</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>Oct 30 1954</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>		8. DATE OF BIRTH <b>March 14 1904</b>	
9. AGE (In years last birthday) <b>50</b>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 2 HRS. Hours _____ Min. _____		11. BIRTHPLACE (State or foreign country) <b>St Louis Mo.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Housework</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>			
13a. FATHER'S NAME <b>John Bielicki</b>		13b. MOTHER'S MAIDEN NAME <b>Agnes Sobczak</b>		14. NAME OF HUSBAND OR WIFE <b>Herman</b>			
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 <b>Herman Chott</b> ADDRESS <b>4516 Oregon Av</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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION 1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Atherosclerotic Heart Disease.</b> ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Myocardial Stenosis.</b> DUE TO (c) <b>Auricular Fibrillation.</b> 2. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death. <b>Atherosclerosis</b>				INTERVAL BETWEEN ONSET AND DEATH _____	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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>410X</b>			
22. I hereby certify that I attended the deceased from <b>Jan</b> , 19 <b>53</b> to <b>Oct</b> , 19 <b>54</b> , that I last saw the deceased alive on <b>10/30</b> , 19 <b>54</b> , and that death occurred at <b>10:30 P</b> m., from the causes and on the date stated above.							
23a. SIGNATURE <b>J. O. Mowrey</b> (Degree or title) <b>M.D.</b>				23b. ADDRESS <b>3625 Fair</b>		23c. DATE SIGNED <b>11/1/54</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>11/3/54</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>		24d. LOCATION (City, town, or county) (State) <b>St Louis Missouri</b>	
DATE REC'D BY LOCAL REG. <b>NOV 1 1954</b>		REGISTRAR'S SIGNATURE <b>J. Earl Smith, md</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Moydell Funeral Home</b> ADDRESS <b>1926 Allen Av</b>			

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

M. J. B. (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 .....  
Student Embalmer

Signed *Richard K. Lehmann*

Licensed Embalmer No. *3395*

P. O. Address *St. Louis 4/7/12*

**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.