

No. 300
10.48

FILED NOV 22 1954

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 39087

XC 395 57 99

SL# 3390

318

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Registrar's No. 9866

BIRTH NO. REG. DIST. NO. PRIMARY REG. DIST. NO.

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|---|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE ILLINOIS | | b. COUNTY SAINT CLAIR | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN 195 N. Grand Blvd. St. Louis, Missouri | | c. LENGTH OF STAY (in this place) 3 DAYS | | c. CITY OR TOWN EAST ST. LOUIS | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL | | e. STREET ADDRESS 5302 EASTGATE | | d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |

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|--|---------------------------|--|--|--|-----------------------------------|--|
| 3. NAME OF DECEASED (Type or Print) a. (First) BEN b. (Middle) J. c. (Last) PANEK | | | 4. DATE OF DEATH (Month) (Day) (Year) 10-29-54 | | | |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) DIVORCED | 8. DATE OF BIRTH 1-10-14 | 9. AGE (In years last birthday) 40 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DRY CLEANER | | 10b. KIND OF BUSINESS OR INDUSTRY DRY CLEANING | | 11. BIRTHPLACE (City and State or Foreign Country) EAST ST. LOUIS, ILLINOIS | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |

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|--|--|--|--|--|--|
| 13a. FATHER'S NAME JOSEPH PANEK | | 13b. MOTHER'S MAIDEN NAME MARY DUCAL | | 14. NAME OF HUSBAND OR WIFE NONE | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES | | 16. SOCIAL SECURITY NO. WWII 355-05-4397 | | 17. INFORMANT'S SIGNATURE OR NAME VA HOSPITAL RECORDS, ST. LOUIS, MO. | |

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|--|--|---|--|---|--|
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) | | MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) CASEOUS TUBERCULOSIS | | INTERVAL BETWEEN ONSET AND DEATH UNKNOWN | |
| *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death. | | 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. | | | |

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|---|--|--|--|---|--|
| 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? 008X | |

22. I hereby certify that I attended the deceased from 10-26, 1954, to 10-29, 1954, and that death occurred at 9:00p. m., from the causes and on the date stated above.

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|---|--|---------------------------|--|-------------------------------------|--|------------------------------|--|
| 23a. SIGNATURE John M. McCarthy JOHN M. MC CARTHY | | (Degree or title) M.D. | | 23b. ADDRESS VAH, ST. LOUIS, MO. | | 23c. DATE SIGNED 10-30-54 | |
|---|--|---------------------------|--|-------------------------------------|--|------------------------------|--|

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|--|--|----------------------|--|--|--|---|--|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Removal | | 24b. DATE 11-1-54 | | 24c. NAME OF CEMETERY OR CREMATORY St. Adalbert | | 24d. LOCATION (City, town, or county) (State) Catherineborough Ill | |
|--|--|----------------------|--|--|--|---|--|

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|--|--|---|--|---|--|-------------------|--|
| DATE REC'D BY LOCAL REG. NOV 1 1954 | | REGISTRAR'S SIGNATURE H. Earl Smith MD | | 25. FUNERAL DIRECTOR'S SIGNATURE John A. ... | | ADDRESS C. ... | |
|--|--|---|--|---|--|-------------------|--|

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFAADING 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 A. Agnoski*.....
Licensed Embalmer No. *3398*.....
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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.