

FILED NOV 22 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

1003- State File No. 39374  
318 PRIMARY REG. DIST. NO. Registrar's No. 9726

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St Louis Mo		c. CITY OR TOWN St Louis	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 Alexian Brothers Hospital		e. STREET ADDRESS (If rural, give location) 9 4442 Athlone Avenue 20970	
3. NAME OF DECEASED (Type or Print) a. (First) Peter J b. (Middle) (Piotr) WOJCIECHOWSKI c. (Last)			4. DATE OF DEATH (Month) (Day) (Year) 10- 24-54
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Oct 11 1890
9. AGE (In years last birthday) 64		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk	11. BIRTHPLACE (City and State or Foreign Country) St Louis Mo
10a. USUAL OCCUPATION		10b. KIND OF BUSINESS OR INDUSTRY Guar. Land & Title	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME Michael Wojciechowski		13b. MOTHER'S MAIDEN NAME Joann Mendak	14. NAME OF HUSBAND OR WIFE Hedwig Wojciechowski
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 493-07-0865	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Hedwig Wojciechowski 4442 Athlone
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) acute coronary occlusion		INTERVAL BETWEEN ONSET AND DEATH 15 min.	
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		DUE TO (b) Aneurysm of abdominal aorta 2 to 3 yrs	
DUE TO (c) Atherosclerotic heart disease 2 to 3 yrs			
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 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? 4200			
22. I hereby certify that I attended the deceased from 10/23, 1954, to 10/24, 1954, that I last saw the deceased alive on 10/24, 1954, and that death occurred at 12:40 P.M., from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) J. Earl Smith, M.D.		23b. ADDRESS 1901 Madison St	
23c. DATE SIGNED 10/26/54			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 10-28-54	
24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery		24d. LOCATION (City, town, or county) (State) St Louis Mo	
DATE REC'D BY LOCAL REG. OCT 26 1954		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS John Stygar & Son 5541 Rievervie Blvd	

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

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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 *J. W. Rister*.....

Licensed Embalmer No. *3986*

P. O. Address *St. Louis*

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.