

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

44242

State File No. ....

FILED JAN 27 1955

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 546 Registrar's No. 2843

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Overland</u>		c. LENGTH OF STAY (In this place) <u>11 yrs</u>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>2409 Gilrose Ave</u>		e. STREET ADDRESS (If rural, give location) <u>2409 Gilrose Ave</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>Alexander</u> b. (Middle) <u>S.</u> c. (Last) <u>Macinski</u>			4. DATE OF "DEATH" (Month) (Day) (Year) <u>Dec. 9 1954</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Feb 23 1890</u>	9. AGE (In years last birthday) <u>64</u>	IF UNDER 1 YEAR Hours _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Stevadore</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>C.R.T. R.R.</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Poland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>

13a. FATHER'S NAME <u>John Macinski</u>		13b. MOTHER'S MAIDEN NAME <u>Unknown</u>		14. NAME OF HUSBAND OR WIFE <u>Joanna Macinski</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>707-16-2930</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. J. Macinski 2409 Melrose Av.</u>	

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) <u>Arteriosclerosis, pt. brain</u> <u>Coronary heart disease</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u>	
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?	

22. I hereby certify that I attended the deceased from Dec 1, 1954 to 12-9-, 1954, that I last saw the deceased alive on 11-9-, 1954, and that death occurred at 5:30 p.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Henry W. Moir M.D.</u>		23b. ADDRESS <u>2438 Woodson Rd</u>		23c. DATE SIGNED <u>12/9/54</u>	
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24a. SERIAL, CREMATION REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>12-11-54</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>St. Louis Mo.</u>	
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DATE REC'D BY LOCAL REG. <u>12/9/54</u>		REGISTRAR'S SIGNATURE <u>Hebeack</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>John Stygar &amp; Son 6341 Riverview</u>	
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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. M. Ruster*

Licensed Embalmer No. *3980*

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.