

FILED AUG 2 - 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 23993

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 5922

1. PLACE OF DEATH
a. COUNTY 0
2. USUAL RESIDENCE (Where deceased lived. If institution: residence before death)
a. STATE Missouri b. COUNTY 2239

b. CITY (If outside corporate limits, write RURAL and give township) c. LENGTH OF STAY (in this place)
ST. LOUIS Mo
c. CITY OR TOWN ST. LOUIS
d. Is Residence within limits of a city or incorporated town? Yes No 0

d. FULL NAME OF HOSPITAL OR INSTITUTION Missouri Baptist Hosp. 23
STREET ADDRESS (If rural, give location) 2619 OREGON

3. NAME OF DECEASED
a. (First) PETER b. (Middle) KOSTECKI c. (Last)
4. DATE OF DEATH (Month) (Day) (Year) JULY 7 1955

5. SEX MALE 6. COLOR OR RACE WHITE 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED MARRIED 8. DATE OF BIRTH JUNE 23 1879
9. AGE (In years last birthday) 76 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) RETIRED ROLLER 10b. KIND OF BUSINESS OR INDUSTRY INT. SHOE CO 11. BIRTHPLACE (City and State or Foreign Country) New York 1 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME ANTHONY KOSTECKI 13b. MOTHER'S MAIDEN NAME MARY LUCHAK 14. NAME OF HUSBAND OR WIFE JOSEPHINE KOSTECKI

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no. or unknown) 16. SOCIAL SECURITY NO. 17. INFORMANT'S SIGNATURE OR NAME ADDRESS JOSEPHINE KOSTECKI 2619 OREGON

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)
19. MEDICAL CERTIFICATION
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of sigmoid colon
ANTECEDENT CAUSES: Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) emission of urinary blood DUE TO (c) anemia
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. anemia
INTERVAL BETWEEN ONSET AND DEATH 10 small 4 small 62 days

19a. DATE OF OPERATION APR 26, 1955 19b. MAJOR FINDINGS OF OPERATION exploratory laprotomy cancer 20. AUTOPSY? YES NO

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) 153 x

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) 21e. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 21f. HOW DID INJURY OCCUR? 153 x

22. I hereby certify that I attended the deceased from April 1955, to July 7, 1955, that I last saw the deceased alive on July 6, 1955, and that death occurred at 4 p.m., from the causes and on the date stated above.

23a. SIGNATURE D. J. Verda M.D. (Degree or title) 23b. ADDRESS 4500 Olive 23c. DATE SIGNED 11/8/55

24a. BURIAL, CREMATION, REMOVAL (Specify) 24b. DATE JULY 11 1955 24c. NAME OF CEMETERY OR CREMATORY RESURRECTION 24d. LOCATION (City, town, or county) (State) ST. LOUIS Co., Mo.

DATE REC'D BY LOCAL REG. JUL 8 1955 REGISTRAR'S SIGNATURE J. Earl Smith, M.D. 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Thomas Lutes 2906 Prairie

S.P. (Licensed Embalmer's Statement on Reverse Side)

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

for 17... 349
Thurs. 3 to 7 P.M.
leath 4 - 45 P.M.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was em
by me, or by Student Embalmer No.....
working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed..... *Leo J. Budd*
Licensed Embalmer No..... 39
P. O. Address..... *St. Louis*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING.
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.