

FILED AUG 10 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

24795
State File No. 1627
Registrar's No.

BIRTH NO. _____ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 547

1. PLACE OF DEATH a. COUNTY ST. LOUIS		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo b. COUNTY _____	
b. CITY OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
c. LENGTH OF STAY (In this place) 30 days		d. STREET ADDRESS (If rural, give location) 3419 Cassonade	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Mary's Hospital			

3. NAME OF DECEASED a. (First) Sister Mary Bernice b. (Middle) Wilczewski c. (Last) _____			4. DATE OF DEATH (Month) (Day) (Year) 7-17-55		
5. SEX F.		6. COLOR OR RACE W.		8. DATE OF BIRTH 1-17-18	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) NEVER MARRIED		9. AGE (In years last birthday) 38		10. USUAL OCCUPATION (Other kind of work done during most of working life, even if retired) School Teacher	
10b. KIND OF BUSINESS OR INDUSTRY RETIRED		11. BIRTHPLACE (City and State or Foreign Country) Omaha, Nebraska		12. CITIZEN OF WHAT COUNTRY? U.S.A.	

13a. FATHER'S NAME Joseph Wilczewski		13b. MOTHER'S MAIDEN NAME Mary Krantz		14. NAME OF HUSBAND OR WIFE NONE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT'S SIGNATURE OR NAME Trammi Steh	
				ADDRESS 3419 Cassonade	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i>		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Malnutrition ANTECEDENT CAUSES Ulcerations Colitis 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
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Poisoning				

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 _____, 1955 to 7-17, 1955 that I last saw the deceased alive on 7-14, 1955 and that death occurred at 2:30 p.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) T. M. ...		23b. ADDRESS 4161 ...		23c. DATE SIGNED 7/18/55	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 7/19/55		24c. NAME OF CEMETERY OR CREMATORY St. Joseph	
				24d. LOCATION (City, town, or county) (State) Bergeron Mo	

DATE REC'D BY LOCAL REG. 7/18/55		REGISTRAR'S SIGNATURE Hebert G. Donker		25. FUNERAL DIRECTOR'S SIGNATURE Central ...		ADDRESS 1841 Cass ...	
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WRITE PLAINLY—USING UNFADING 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
Student Embalmer

Signed *J. W. Binkley*
Licensed Embalmer No. *36513*
P. O. Address *St. Louis, Mo.*

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.