

FILED JAN 17 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 42319

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 11529

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. LENGTH OF STAY (In this place) _____
c. CITY OR TOWN St Louis
d. Is Residence within limits of a city or incorporated town? Yes No

d. FULL NAME OF HOSPITAL OR INSTITUTION Faith Hospital
e. STREET ADDRESS (If rural, give location) 26 1408 Haven St. 226/6

3. NAME OF DECEASED a. (First) Emma b. (Middle) Lepski c. (Last) Lesky
(Type or Print) 4. DATE OF DEATH (Month) (Day) (Year) 12-28-55

5. SEX Femal 6. COLOR OR RACE White 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widdow 8. DATE OF BIRTH July 10/88
9. AGE (In years last birthday) 67 IF UNDER 1 YEAR Months Days IF UNDER 1 HR. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pension 10b. KIND OF BUSINESS OR INDUSTRY _____
11. BIRTHPLACE (City and State or Foreign Country) St Louis Mo 12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME Peter Narkiewicz 13b. MOTHER'S MAIDEN NAME Anna Czuchonski 14. NAME OF HUSBAND/OR WIFE Deceased

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No No 16. SOCIAL SECURITY NO. _____ 17. INFORMANT'S SIGNATURE OR NAME Mrs Leona Clifford 18. ADDRESS 7849 Bloom ave

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) TERMINAL UREMIA
ANTECEDENT CAUSES DUE TO (b) TERMINAL BRONCHOPNEUMONIA
DUE TO (c) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE
II. OTHER SIGNIFICANT CONDITIONS Vascular heart disease - acute cardiac decompensation - nephrosclerosis
INTERVAL BETWEEN ONSET AND DEATH 1 DAY 3 to 5 yrs

19a. DATE OF OPERATION _____ 19b. MAJOR FINDINGS OF OPERATION nephrosclerosis 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) 4200

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

22. I hereby certify that I attended the deceased from 12/10, 1955, to 12/28, 1955, that I last saw the deceased alive on 12/25, 1955, and that death occurred at 8 P. m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) _____ 23b. ADDRESS 1901 Madison St 23c. DATE SIGNED 12/30/55

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial 24b. DATE 12/31/55 24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery 24d. LOCATION (City, town, or county) (State) St Louis Mo

DATE REC'D BY LOCAL REG. DEC 30 1955 REGISTRAR'S SIGNATURE J. Carl Smith M.D. 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Central Und Co 1841 Cass ave

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

PR 18102

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. Rister

Licensed Embalmer No. 390

P. O. Address *St. Louis,*

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