

FILED JAN 17 1956

THE DIVISION OF HEALTH OF THE STATE OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **42331**

318

PRIMARY REG. DIST. NO. **1003**

Registrar's No. **11626**

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		Registrar's No. _____	
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) 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 <input type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION 1522 N.17th Str.				STREET ADDRESS (If rural, give location) 26 1522N 17th Str. 226/2			
3. NAME OF DECEASED (Type or Print) Teofila		b. (Middle) _____		c. (Last) Liszewski		4. DATE OF DEATH (Month) (Day) (Year) 12 - 31 - 55	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Nov 1-88		9. AGE (In years last birthday) 67	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) Housewife		10b. KIND OF BUSINESS OR INDUSTRY #####		11. BIRTHPLACE (City and State or Foreign Country) Poland		12. CITIZEN OF WHAT COUNTRY? 199	
13a. FATHER'S NAME Simon Andruskiewicz			13b. MOTHER'S MAIDEN NAME Johann Arshowski		14. NAME OF HUSBAND OR WIFE Stanley Liszewski		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Stanley Liszewski 1522N, 17th St			
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, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) CEREBRAL HEMORRHAGE (RIGHT)					INTERVAL BETWEEN ONSET AND DEATH 2 DAYS	
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) CHRONIC MYOCARDITIS (WITH DILATATION)					35 DAYS	
	DUE TO (c) ARTERIOSCLEROSIS					1 YEAR	
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. DIABETES MELLITUS					2 YEARS	
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 NOV 16, 1955 , to DEC 31, 1955 , that I last saw the deceased alive on Dec 31, 1955 , and that death occurred at 3:00 A.M. , from the causes and on the date stated above.							
23a. SIGNATURE Anthony A. Prokash M.D. (Degree or Title)				23b. ADDRESS 1525 a Cass Ave		23c. DATE SIGNED Jan. 2, 56	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 1-3-56	24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery		24d. LOCATION (City, town, or county) (State) St Louis Mo		
DATE REC'D BY LOCAL REG. JAN 3 1956		REGISTRAR'S SIGNATURE Carl Smith MD		25. FUNERAL DIRECTOR'S SIGNATURE Central Und Co		ADDRESS 1841 Cass ave	

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.....
Signature of Student Embalmer

Signed *JW Ruster*

Licensed Embalmer No. *398*
P. O. Address *St Louis 9*

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.