

FILED MAR 5 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **6366**
Registrar's No. **1552**

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		a. STATE Missouri b. COUNTY	
c. LENGTH OF STAY (in this place)		c. CITY OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION 8650 Oriole Avenue		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
e. STREET ADDRESS (If rural, give location) 8650 Oriole Ave.			

3. NAME OF DECEASED (Type or Print)	a. (First) GEORGE	b. (Middle)	c. (Last) DEPTULA	4. DATE OF DEATH (Month) (Day) (Year)
				Feb. 12, 1956

5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Mar. 1862	9. AGE (In years last birthday) 93	IF UNDER 1 YEAR Months	IF UNDER 4 HRS. Hours	Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed	10b. KIND OF BUSINESS OR INDUSTRY none	11. BIRTHPLACE (City and State or Foreign Country) Poland	12. CITIZEN OF WHAT COUNTRY U.S.A.
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13a. FATHER'S NAME Unknown	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Deceased.
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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 Helen Noonan	ADDRESS 8650 Oriole Avenue
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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.	1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic Endocarditis		INTERVAL BETWEEN ONSET AND DEATH 2 yrs
	ANTECEDENT CAUSES Morbid conditions, if any, giving DUE TO (b) rise to the above cause (a) stating the underlying cause last.		
	DUE TO (c) 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"/>
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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 **Mar 13, 1954**, to **Feb 12, 1956**, that I last saw the deceased alive on **Feb 12, 1956**, and that death occurred at **6:30 p.m.**, from the causes and on the date stated above.

23a. SIGNATURE [Signature]	(Degree or title) MD	23b. ADDRESS 2803 N. Kingshighway	23c. DATE SIGNED 2/13/56
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 2/15/56	24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	24d. LOCATION (City, town, or county) (State) St. Louis, Missouri
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DATE REC'D BY LOCAL REG. FEB 14 1956	REGISTRAR'S SIGNATURE [Signature]	25. FUNERAL DIRECTOR'S SIGNATURE John Stygar & Son	ADDRESS 5541 Riverview Bl.
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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.....
Signature of Student Embalmer

Signed *JM Pister*.....
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.