

FILED AUG 22 1956

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

29499

State File No. _____
 Registrar's No. 1796

BIRTH NO. _____ REG. DIST. NO. 312 PRIMARY REG. DIST. NO. 500

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, write RURAL and give town) OR TOWN Koch, Mo		c. LENGTH OF STAY (in this place) 69 mos.	
d. FULL NAME OF HOSPITAL OR INSTITUTION Robert Koch Hospital		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or Print)		e. STREET ADDRESS (If rural, give location)	
a. (First) Joseph	b. (Middle) John	c. (Last) Parciak	
4. DATE OF DEATH		5. SEX	
(Month) 7	(Day) 26	(Year) 56	
6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	
8. DATE OF BIRTH 3-17-11		9. AGE (In years last birthday) 42	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Various	
11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Mo.		12. CITIZEN OF WHAT COUNTRY? USA	

2269

13a. FATHER'S NAME Walter Parciak		13b. MOTHER'S MAIDEN NAME Katherine Kacorek		14. NAME OF HUSBAND OR WIFE Jennie Parciak	
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. 498107-3386		17. INFORMANT'S SIGNATURE OR NAME Records Koch Hospital, Koch, Mo	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary Tuberculosis		INTERVAL BETWEEN ONSET AND DEATH 6 yrs	
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.			
		DUE TO (b) _____			
		DUE TO (c) _____			
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?	

002X

22. I hereby certify that I attended 56 deceased from 4-20 7:55am to 7-26, 19 56 that I last saw the deceased alive on 19, and that death occurred at 7:55am, from the causes and on the date stated above.

23a. SIGNATURE **H. A. Harris** (Degree or title) **MD**

23b. ADDRESS **Koch Hospital, Koch, Mo.**

23c. DATE SIGNED **7-26-56**

24a. BIRTHPLACE (City, town, or county) **St. Louis Mo**

24b. DATE **7/28/56**

24c. NAME OF CEMETERY OR CREMATORY **Calvary Cemetery**

24d. LOCATION (City, town, or county) (State) **St Louis Mo**

DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE **7-27-56** **Herbert R. ...**

25. FUNERAL DIRECTOR'S SIGNATURE **Central Und Co** ADDRESS **1841 Cass ave**

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

ANN 29 1963

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. P. Rister*

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.