

Health,  
Welfare  
Public  
Service

300  
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

FILED SEP 21 1956

STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **8013**

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY						
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>St. Louis</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>10912 Riverview Dr. 1 Mo</b>			Length of stay in the	d. STREET ADDRESS <b>20333 Sullivan</b>		(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>Julia Koprowski</b>				First	Middle	Last	4. DATE OF DEATH Month <b>8</b> Day <b>29</b> Year <b>1956</b>			
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10-29-1877</b>		9. AGE (In years last birthday) <b>78</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>Poland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>John Ogdorny</b>				14. MOTHER'S MAIDEN NAME <b>Eva Szczuberek</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Joseph Koprowski 10912 Riverview Dr</b>						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cocciemia of liver, Stomach &amp; Intestines &amp; Pulmonary infarct.</b> Conditions, if any, which have led to this cause (a), (b) or (c) <b>due to (a) Cocciemia of liver, Intestine</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>1998</b>								INTERVAL BETWEEN ONSET AND DEATH <b>18 hrs</b>		
20a. ACCIDENT <input type="checkbox"/>	SUICIDE <input type="checkbox"/>	HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a. m. p. m.			20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>							
20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY		STATE				
21. I attended the deceased from <b>8-28-56</b> to <b>8-29-56</b> and last saw her alive on <b>8-28-56</b> Death occurred at <b>5:00</b> m on the date stated above; and to the best of my knowledge, from the causes stated.										
22a. SIGNATURE <i>W. A. King</i> (Degree by title)				22b. ADDRESS <b>82014 Broadway</b>				22c. DATE SIGNED <b>8/30/56</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City, town, or county) (State)				
<b>Burial</b>		<b>8-31-56</b>	<b>Calvary</b>			<b>St. Louis Mo.</b>				
24. FUNERAL DIRECTOR ADDRESS <b>B. Kosakowski &amp; Sons Funeral Home</b>				25. DATE RECD. BY LOCAL REG. <b>AUG 30 1956</b>		26. REGISTRAR'S SIGNATURE <i>Carl Smith MD</i>				

(Licensed Embalmer's Statement on Reverse Side)

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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 *John S. Wenn*.....  
Licensed Embalmer No. *719*.....  
P. O. Address *St. Louis*.....

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