

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **43337**
Registrar's No. **11885**

FILED JAN 15 1957

318

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BIRTH NO. _____ REG. DIST. NO. _____ PRIMARY REG. DIST. 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. CITY OR TOWN St. Louis, Mo.	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis Chronic Hospital		e. STREET ADDRESS (If rural, give location) 5800 Arsenal St.	

3. NAME OF DECEASED (Type or Print) JOHN KING			4. DATE OF DEATH (Month) (Day) (Year) December 15, 1956		
5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) UNKNOWN		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) Michigan.	

13a. FATHER'S NAME John King		13b. MOTHER'S MAIDEN NAME Jane (Unknown)		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) UNKNOWN		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Hospital Records-5800 Arsenal St.	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) Adenocarcinoma of Prostate		1 yr?	
ANTECEDENT CAUSES		DUE TO (b) Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.			
		DUE TO (c) 177x			
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Pulmonary Metastasis of above		1 yr	

19a. DATE OF OPERATION 2-21-56		19b. MAJOR FINDINGS OF OPERATION Adenocarcinoma of Prostate		20. AUTOPSY? YES <input type="checkbox"/> NO <input 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 October 31, 1956, to Dec. 15, 1956, that I last saw the deceased alive on Dec. 15, 1956, and that death occurred at 1:20A m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) John Niedzwizinski, M.D.		23b. ADDRESS 5800 Arsenal St. Louis		23c. DATE SIGNED 12-15-56	
24a. BURIAL, CREMATION, REMOVAL (Specify) 12-31-56		24b. DATE		24c. NAME OF CEMETERY OR CREMATORY Anatomical Board	
				24d. LOCATION (City, town, or county) (State) St. Louis, Mo.	

DATE REC'D BY LOCAL REG. DEC 27 1956		REGISTRAR'S SIGNATURE Paul Smith M.D.		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Rowland-Aker Mortuary Service	
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(Licensed Embalmer's Statement on Reverse) 6102 Manchester Ave. St. Louis 10, Mo.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was
by me, or by, Student Embalmer No.....
working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed.....

Licensed Embalmer No.....

P. O. Address

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