

Health, Welfare & Public Service

800-56

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED JAN 15 1957

436889
STATE FILE NUMBER
11657

Registration District No. 318 Primary Registration District No. 1003

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN ST. LOUIS		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 6523 O'DELL			Length of stay in lb 12 YRS		STREET ADDRESS 6523 O'DELL (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) ANNA First Middle Last POPOWCHAK				4. DATE OF DEATH Month 12 Day 18 Year 56			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6-26-1910		9. AGE (In years last birthday) 46	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY AT-HOME		11. BIRTHPLACE (City and state or country) PENN.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME LOUIS-WASYLENKO				14. MOTHER'S MAIDEN NAME MARY-POPOWCHAK			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 498-26-6315		17. INFORMANT Address FRANK-POPOWCHAK-6523 O'DELL			
18. CAUSE OF DEATH [Enter only one cause per line for (a); (b); and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion, recurrent Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) 420.1 DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Rheumatic Heart Disease							INTERVAL BETWEEN ONSET AND DEATH 1 month
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 Month, Day, Year 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 1955 to 12/18/56 and last saw her/him alive on 12/17/56 . Death occurred at 8 m of the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE Walter J. Doyle (Degree or title)				22b. ADDRESS 3915 Watson Rd		22c. DATE SIGNED 12/19/56	
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	23b. DATE 12-19-56	23c. NAME OF CEMETERY OR CREMATORY BENLD-ILL. CEM.		23d. LOCATION (City, town, or county) BENLD- ILL.		(State)	
24. FUNERAL DIRECTOR UNION-FUNERA-HM. BENLD- ILL.			25. DATE RECD. BY LOCAL REG. DEC 20 1956		26. REGISTRAR'S SIGNATURE J. Earl Smith m.d.		

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. Burgess*

Licensed Embalmer No. *40*

P. O. Address *Maple*

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..