

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

10884

FILED MAR 27 1957

318

1003

STATE FILE NUMBER

2392

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

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 type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>St. Louis</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Faith Hospital</b>		Length of stay in lb <b>2089</b>		STREET ADDRESS (If outside, give location) <b>1123 Canaan Ave.</b>	
10. HOSPITAL OR INSTITUTION		11. RESIDE ON FARM Yes <input type="checkbox"/> No <input type="checkbox"/>		4. DATE OF DEATH Month Day Year <b>Mar. 8, 1957</b>	
3. NAME OF DECEASED (Type or print) <b>LEOKADYA (PODOLSKA) PODORSKI</b>		First Middle Last		9. AGE (In years last birthday) <b>74</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</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>Apr. 18, 1882</b>		9. AGE (In years last birthday)		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Hosuewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (City and state or country) <b>Germany 4</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no none</b>		16. SOCIAL SECURITY NO. <b>492-03-4112A</b>		17. INFORMANT Address <b>Mr. Leo Podorski 1123 Canaan Avenue</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>Acute Coronary Ischemia</b> <b>Arterio Sclerotic Cordis Vasculum</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c) <b>Cholelithiasis Choleliths of Gallbladder</b>		INTERVAL BETWEEN ONSET AND DEATH <b>24 hours</b> <b>5 yrs.</b> <b>3 yrs.</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		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.) <b>422.1</b>	
20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m.		20d. INJURY OCCURRED WHILE AT <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		20g. COUNTY		20h. STATE	
21. I attended the deceased from <b>4/12/54</b> to <b>3/8/57</b> and last saw her/him alive on <b>3/8/57</b> . Death occurred at <b>4:15 P.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <b>A. J. Leopold M.D.</b>		22b. ADDRESS <b>1901 Madison St.</b>		22c. DATE SIGNED <b>3/9/57</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Mar. 11, 1957</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>	
23d. LOCATION (City, town, or county) <b>St. Louis, Missouri</b>		23e. (State)		24. FUNERAL DIRECTOR ADDRESS <b>JOHN STYGAR &amp; SON - 5541 RIVERVIEW BLVD.</b>	
25. DATE RECD. BY LOCAL REG. <b>MAR 11 57</b>		26. REGISTRAR'S SIGNATURE <b>J. Earl Smith, M.D.</b>		27. <b>M. J. B.</b>	

Health, & Welfare Public Services  
S. 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 casually related. Coroner cannot certify to a death due to natural causes.  
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
securing the medical certification in the specific manner required by 1937, 1940 and 1957.

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. M. Ristea*.....

Licensed Embalmer No. *398*.....

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.