

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

29619
STATE FILE NUMBER 7962

FILED SEP 4 1957

318

1003

Registrar's No.

Registration District No. Primary Registration District No.

1. PLACE OF DEATH a. COUNTY:			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY Mo			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St Louis Mo		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St Louis		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 1730 a N. 20th str			Length of stay in 1b		d. STREET ADDRESS (If outside, give location) 1730a N. 20th Str	
3. NAME OF DECEASED (Type or print) Stanley			First (Kokonek)		Last Kaczorek	
4. DATE OF DEATH 8/24/57		Month 8 Day 24 Year 57		5. SEX Male		
6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/8/92		
9. AGE (In years last birthday) 65		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Woodworker		11. BIRTHPLACE (City and state or country) Poland		
10a. USUAL OCCUPATION		10b. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? Yes		
13. FATHER'S NAME John Kaczorek			14. MOTHER'S MAIDEN NAME Maryann Gacio			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) War 1		16. SOCIAL SECURITY NO. 499-01-3385		17. INFORMANT Felicia Kaczorek 1730a N 20th Str		
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					INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					DUE TO (b)	
					DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (r) 4201					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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. Month, Day, Year 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 St Louis COUNTY Mo STATE Mo		
21. I attended the deceased from Aug 23-1957 and last saw her/him alive on Aug 27/57 Death occurred at 12 P m on the date stated above; and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE J. P. Smith		22b. ADDRESS 3511 Universe to St Louis		22c. DATE SIGNED Aug 26		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 8/27/57		23c. NAME OF CEMETERY OR CREMATORY National Cemetery		
23d. LOCATION (City, town, or county) St Louis County		23e. STATE Mo				
24. FUNERAL DIRECTOR Central Und, Co		ADDRESS 1841 Cass ave		25. DATE RECD. BY LOCAL REG. AUG 26 57		
26. REGISTRAR'S SIGNATURE J. Paul 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. W. Pister

Licensed Embalmer No. 39

P. O. Address St. Louis

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.