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FILED OCT 14 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

33844
STATE FILE NUMBER 9094

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

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St Louis Mo — Inside Limits Yes ☐ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): Mo. Baptist — Length of stay in 1b: 7 days

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mo
b. COUNTY:
c. CITY OR TOWN: St Louis — Inside Limits Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location): 1126a Cass ave — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First Walter Middle Last Majewski
4. DATE OF DEATH: Month Day Year 9/27/57
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Sept 14/06
9. AGE (In years last birthday): 51 — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Self employed
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (City and state or country): St Louis Mo
12. CITIZEN OF WHAT COUNTRY? Yes
13. FATHER'S NAME: Anthony Majewski
14. MOTHER'S MAIDEN NAME: Mary Orzel
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Harriet Majewski — Address: 1126a Cass ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pulmonary Embolism — INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Post Operative 454X — 1 min
DUE TO (c): Abdominal Aortic Replacement
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Leriche Syndrome Thrombosis Abd. Aorta
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
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 [illegible], to [illegible] and last saw ~~her~~ him alive on 9/27/57
Death occurred at 11:15 Am m on the date stated above; and to the best of my knowledge, from the causes stated.
22a. SIGNATURE: Everett R. Kennell (Degree or title) MD
22b. ADDRESS: 453 N. Taylor Ave.
22c. DATE SIGNED: 9/30/57

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: Oct 1-57
23c. NAME OF CEMETERY OR CREMATORY: Calvary Cemetery
23d. LOCATION (City, town, or county) (State): St Louis Mo
24. FUNERAL DIRECTOR: Central Funeral Home — ADDRESS: 1841 Cass
25. DATE RECD. BY LOCAL REG.: SEP 30 57
26. REGISTRAR'S SIGNATURE: Karl Smith MD

(Licensed Embalmer's Statement on Reverse Side)

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

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was er

by me, or by ....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed J W Rister

Licensed Embalmer No. 39

P. O. Address St. Lou

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.