

FILED DEC 20 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

46065
STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registration No. **11376**

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 01 4445 BESSIE AVE		Length of stay in 1b		d. STREET ADDRESS (If outside, give location) 210 4445 BESSIE AVE		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JOHN Middle S. Last LORKOWSKI			4. DATE OF DEATH Month NOV , Day 26 , Year 1957				
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 3-24-1896		9. AGE (In years last birthday) 61	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CARTER CORB. CO.		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) ST LOUIS MISSOURI		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME VALENTINE LORKOWSKI				14. MOTHER'S MAIDEN NAME AGNES FUGEL			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES		16. SOCIAL SECURITY NO. WORLD 1 # 489-09-7007		17. INFORMANT Address MARY LORKOWSKI 4445 BESSIE AVE			
18. CAUSE OF DEATH (Enter only one cause per line for (a); (b); and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute Myocardial Failure Conditions, if any, which gave rise to above "cause" (a), stating the underlying cause last. DUE TO (b) coronary atherosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 434.2							INTERVAL BETWEEN ONSET AND DEATH
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 5-9-57 to 11-26-57 and last saw him him alive on 11-16-57 Death occurred at 9:30 4 m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) Dr. Robert M. D.				22b. ADDRESS 4110 W. Florentine Ave		22c. DATE SIGNED 11-27-57	
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		23b. DATE 11-30-57	23c. NAME OF CEMETERY OR CREMATORY ST MONICIA CEMETERY		23d. LOCATION (City, town, or county) (State) CREVE COEUR MO.		
24. FUNERAL DIRECTOR ADDRESS STROOT - CARROLL 4600 NATURAL BRIDGE				25. DATE RECD. BY LOCAL REG. NOV 27 57		26. REGISTRAR'S SIGNATURE Carl Smith MD	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

W 188 24
Marriss
4110 W. Flourent
8 am Wed

STATEMENT BY LICENSED EMBALMER

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

Student.....
Signature of Student Embalmer

Signed *M W Rueter*

Licensed Embalmer No. *480*

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.