

Health,
Welfare
Public
Service

FILED JAN 30 1958

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

3638
STATE FILE NUMBER
575

Registration District No. 318 Primary Registration District No. 1003

300
1-57

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		c. CITY OR TOWN ST. LOUIS	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION CITY-HOSPITAL #1.		d. STREET ADDRESS (If outside, give location) 2610 1439-REAR=CHAMBERS-ST	
3. NAME OF DECEASED (Type or print) First Middle Last STEVE (STANISLAW) STACHELEK		4. DATE OF DEATH Month Day Year JAN. 16 TH 1958	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC. 25 TH 1895
9. AGE (In years last birthday) 62 YRS.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE	11. BIRTHPLACE (City and state or country) POLAND
12. CITIZEN OF WHAT COUNTRY? POLAND		13. FATHER'S NAME ANTHONY - STACHELEK	
14. MOTHER'S MAIDEN NAME ANNA - SKOPNIK		15. NAME OF HUSBAND OR WIFE < NEVER-MARRIED >	
16. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		17. SOCIAL SECURITY NO. NONE	
18. INFORMANT MARY - GROSSMAN = 1408 NO. MARKET - ST.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gunshot wound of skull and 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 (a) _____			INTERVAL BETWEEN DEATH AND DEATH
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input checked="" type="checkbox"/> <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in PART I or PART II of item 18) Shot in back in house at 1439 Chambers Street about 9:30 am	
20c. TIME OF INJURY .Hour Month, Day, Year 9:00 a.m. 1 15 58		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.) Home		20f. CITY, TOWN, OR LOCATION COUNTY STATE St Louis MO	
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at 4:50 P.M. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree) _____		22b. ADDRESS 1300 Clark	
22c. DATE SIGNED 1/17/58			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE JAN. 18 TH 1958	23c. NAME OF CEMETERY OR CREMATORY CALVARY - CEMETERY	23d. LOCATION (City, town, or county) (State) ST. LOUIS MO.
24. FUNERAL DIRECTOR ADDRESS Brockland Blvd. Co. 1827 - HOGAN - ST.		25. DATE RECD. BY LOCAL REG. JAN 17 58	26. REGISTRAR'S SIGNATURE Carl Smith MO

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Doctor, coroner, etc.: must use only standard nomenclature in item 18. No symptoms with certificate. All diseases in Part I must be causally related.

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

James Binkley

Licensed Embalmer No. *3653*
P. O. Address *St. Louis 8,*

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.