Health, Welfare Public Service

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1-57

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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

58-007260
STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 1858

1. PLACE OF DEATH
a. COUNTY

b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Louis — Inside Limits: Yes [X] No [ ]

c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): VA HOSPITAL — Length of stay in 1b: 12 days

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Illinois b. COUNTY: St. Clair

c. CITY OR TOWN: E. St. Louis — Inside Limits: Yes [X] No [ ]

d. STREET ADDRESS (If outside, give location): 309 N. 6th Street — Reside on Farm: Yes [ ] No [X]

3. NAME OF DECEASED (Type or print) First: Boleslaw Middle: Glovacki Last: (Glowacki)

4. DATE OF DEATH Month Day Year: 2-15-58

5. SEX: male

6. COLOR OR RACE: white

7. MARITAL STATUS: MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: April 13, 1899

9. AGE (In years if over 1 birthday): 58 — 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): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Laborer

11. BIRTHPLACE (City and state or country): Poland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13a. FATHER'S NAME: Ehrlick Glovacki

13b. MOTHER'S MAIDEN NAME: Marianna Lubeck

14. NAME OF HUSBAND OR WIFE: Mary Glovacki

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): WWI

16. SOCIAL SECURITY NO.: 329103524

17. INFORMANT Address: VAH, ST. LOUIS, MO.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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) LIVER FAILURE — INTERVAL BETWEEN ONSET AND DEATH: 2 WKS.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) LAENNECS CIRRHOSIS — YEARS
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): BRONCHO PNEUMONIA 581.1

19. WAS AUTOPSY PERFORMED? YES [X] 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 2-3-58, to 2-15-58 and last saw him alive on 2-15-58
Death occurred at 3:20 P.M. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): M.D.

22b. ADDRESS: VAH, ST. LOUIS, MO.

22c. DATE SIGNED: 2-16-58

23a. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE: 2-17-58

23c. NAME OF CEMETERY OR CREMATORY: National Cemetery

23d. LOCATION (City, town, or county) (State): Jefferson Barrack, Mo.

24. FUNERAL DIRECTOR: Joseph Glovacki — ADDRESS: East St. Louis

(Licensed Embalmer's Statement on Reverse Side)

25. DATE RECD. BY LOCAL REG.: FEB 17 '58

26. REGISTRAR'S SIGNATURE: Paul Smith MD

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 .....

Licensed Embalmer No. 3398

P. O. Address .....

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.