

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-007539

STATE FILE NUMBER

FILED MAR 7 - 1958

318

1003

2403

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

health, Welfare Public Service
300
1-56
All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes. Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <i>Mo</i> b. COUNTY		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>ST. LOUIS</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <i>ST. LOUIS</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>Mo Pac. Hosp.</i>		Length of stay in lb	g. STREET ADDRESS <i>4739 Milentz</i>		h. (If outside, give location) Residence on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <i>EDWIN</i> Middle <i>THEODORE</i> Last <i>MALACHOWSKI</i>			4. DATE OF DEATH Month <i>Feb</i> Day <i>26</i> Year <i>1958</i>		
5. SEX <i>m</i>	6. COLOR OR RACE <i>w</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>NOV. 9 - 1897</i>	9. AGE (In years last birthday) <i>60</i>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>DIST ACCT</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>RAILROAD</i>	11. BIRTHPLACE (City and state or country) <i>MO.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>
13. FATHER'S NAME <i>JOHN MALACHOWSKI</i>			14. MOTHER'S MAIDEN NAME <i>UNK.</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If no, or unknown) (If yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO. <i>HNA</i>	17. INFORMANT Address <i>BARBARA MALACHOWSKI 4737 M. LENTZ</i>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial infarction</i> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <i>Arterio Sclerotic Heart Disease</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>420.0</i>					INTERVAL BETWEEN ONSET AND DEATH <i>1 Day</i> <i>Several Months</i>
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. p. m. Month, Day, Year					
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 <i>Jan 31, 58</i> to <i>2-18-58</i> and last saw him alive on <i>2-18-58</i> Death occurred at <i>8:35 P.M.</i> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <i>Clement P. Sullivan M.D.</i>			22b. ADDRESS <i>Mo. Pac. Emp. Hosp. Assn.</i>		22c. DATE SIGNED <i>2-27-58</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	23b. DATE <i>MAR. 1-1958</i>	23c. NAME OF SEMETERY OR CREMATORY <i>St. Peter & Paul Cem.</i>		23d. LOCATION (City, town, or county) (State) <i>ST. LOUIS MO</i>	
24. FUNERAL DIRECTOR <i>ZIEGENHAIN BROS. 6409 GRAVOIS.</i>		ADDRESS	25. DATE RECD. BY LOCAL REG. <i>FEB 27 '58</i>	26. REGISTRAR'S SIGNATURE <i>Carl Smith MD</i> <i>mfb.</i>	

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 *Van M. Seeger*.....

Licensed Embalmer No. *434*

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.