THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

FILED MAR 19 1958

58-011329
STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 2574

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

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 (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: ST. LOUIS CITY HOSP. #1 — Length of stay in 1b: 25

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MISSOURI
b. COUNTY:
c. CITY OR TOWN: ST. LOUIS — Inside Limits: Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location): 1024 CASS AVE. — Reside on Farm: Yes [ ] No [X]

3. NAME OF DECEASED (Type or print): First: JOHN Middle: Last: BEDNARCZYK

4. DATE OF DEATH: Month: MAR. Day: 1 Year: 1958

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: 11-17-1882

9. AGE (In years last birthday): 75 — 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): TAILOR

10b. KIND OF BUSINESS OR INDUSTRY: CLOTHING

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

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

13a. FATHER'S NAME: UNKNOWN

13b. MOTHER'S MAIDEN NAME: UNKNOWN

14. NAME OF HUSBAND OR WIFE:

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): YES (If yes, give war or dates of service): 6-2-17 To 6-27-19

16. SOCIAL SECURITY NO.:

17. INFORMANT: ELIZABETH ARCZYNSKI Address: 1024 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): Bronchopneumonia, confluent
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH:
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): 491A

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 2-28-58 to 3-1-58 and last saw him alive on 3-1-58
Death occurred at 10:45AM (9:10AM) on the date stated above; and to the best of my knowledge, from the causes stated.

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

22b. ADDRESS: 1515 LAFAYETTE AVE

22c. DATE SIGNED: 3-1-58

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE: 3-4-58

23c. NAME OF CEMETERY OR CREMATORY: NATIONAL

23d. LOCATION (City, town, or county) (State): JEFFERSON BARRACKS MO

24. FUNERAL DIRECTOR ADDRESS: ST. LOUIS FUNERAL HOME 2205 ST. LOUIS AVE.

25. DATE RECD. BY LOCAL REG.: MAR 4 '58

26. REGISTRAR'S SIGNATURE: Earl Smith, Mo M.D.

(Licensed Embalmer's Statement on Reverse Side)

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 Elmo R Cadwell

Licensed Embalmer No. 4077

P. O. Address St Louis

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.