Health, Welfare Public Service

300
1-57

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

FILED MAR 19 1958

THE DIVISION OF HEALTH OF MISSOURI

# STANDARD CERTIFICATE OF DEATH

58-011888
STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 2258

1. PLACE OF DEATH
a. COUNTY

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

c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) 01 2940 Palm St. — Length of stay in 1b

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo — b. COUNTY

c. CITY OR TOWN St. Louis — Inside Limits Yes ☐ No ☐

d. STREET ADDRESS (If outside, give location) 2/0 2940 Palm St. — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First Middle Last: Joseph F. (Kowal) Kowalkowski

4. DATE OF DEATH Month 2 Day 23 Year 58

5. SEX M

6. COLOR OR RACE W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH 6/25/1890

9. AGE (In years of birthday) 67 — 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) Shoe Worker

10b. KIND OF BUSINESS OR INDUSTRY Camille Desighn

11. BIRTHPLACE (City and state or country) St. Louis Mo.

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

13a. FATHER'S NAME Frank Kowalkowski

13b. MOTHER'S MAIDEN NAME Julie

14. NAME OF HUSBAND OR WIFE Bertha Kowalkowski

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

16. SOCIAL SECURITY NO. 488-05-1629

17. INFORMANT Address Frank Landa 2940 Palm

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) Arteriosclerotic heart disease — INTERVAL BETWEEN ONSET AND DEATH 2 yrs.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)
DUE TO (c) 420.0
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒ 2

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 8/9/56, to 2/23/58 and last saw ~~her~~ him alive on 2/20/58
Death occurred at 2:00 pm m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Edw. W. Czebrinski M.D.

22b. ADDRESS 3701 Crandel Sq

22c. DATE SIGNED 2/24/58

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

23b. DATE 2/26/58

23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery

23d. LOCATION (City, town, or county) (State) St. Louis Mo.

24. FUNERAL DIRECTOR ADDRESS Robert D. Kinealy 2228 St. Louis Ave.

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

26. REGISTRAR'S SIGNATURE J Carl Smith Mo M.D.

(Licensed Embalmer's Statement on Reverse Side)

Kimsly Mo.
2228 St
Ch 1-

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 Homer W. Frity

Licensed Embalmer No. 3882

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.