

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-034149

STATE FILE NUMBER 9144

Health,  
& Welfare  
Public  
Service

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. \_\_\_\_\_

**FILED OCT 3 1958**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Illinois</b> b. COUNTY <b>Madison</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> c. CITY OR TOWN <b>Madison</b>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Jewish Hosp.</b>		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) <b>1903 Edwardsville Rd.</b>
3. NAME OF DECEASED (Type or print) First <b>Michael</b> Middle <b>Dobrow</b> Last <b>(Dobromilsky)</b>		4. DATE OF DEATH Month <b>9</b> Day <b>23</b> Year <b>58</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> / DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 15-1894</b>
9. AGE (In years last birthday) <b>63</b>		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Travern Proprietor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Tavern</b>	11. BIRTHPLACE (City and state or country) <b>Poland</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>John Dobromilsky</b>	
14. MOTHER'S MAIDEN NAME <b>unknown</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>	
16. SOCIAL SECURITY NO. <b>327-30-3315</b>		17. INFORMANT <b>Mrs. Sophia Dobrow, Madison, Illinois</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>generalized carcinomatous carcinoma of lung</b>			INTERVAL BETWEEN ONSET AND DEATH <b>4 mos.</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____			<b>6 mos.</b>
DUE TO (c) _____			<b>163x</b>
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 <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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 _____ Month _____ Day _____ a. m. _____ p. m. _____			
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 <b>June 10 1958</b> to <b>Sept 23, 1958</b> and last saw <b>him</b> alive on <b>Sept 22, 1958</b> Death occurred at <b>1 A</b> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>M. Herman Oyel M.D.</b>		22b. ADDRESS <b>100 North Euclid</b>	22c. DATE SIGNED <b>9/23/58</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>9-26-1958</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Sunset Burial Park</b>	23d. LOCATION (City, town, or county) (State) <b>St. Louis Co., Missouri</b>
24. FUNERAL DIRECTOR <b>John L. Sedlack</b> ADDRESS <b>Madison, Illinois</b>		25. DATE REGD. BY LOCAL REG. <b>SEP 23 58</b>	26. REGISTRAR'S SIGNATURE <b>J. Paul Smith, M.D.</b>

(Licensed Embalmer's Statement on Reverse Side)

300 1-56  
 USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
 Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

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.....  
*John J. Sedlacz*

Licensed Embalmer No. *374*

P. O. Address *Madison*

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.