Health, Welfare Public Service

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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-003316
STATE FILE NUMBER

FILED JAN 28 1959 Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 363

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN St. Louis — Inside Limits Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION Our Lady of Perpetual Help Nursing Home — Length of stay in this place 15 years

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) 3419 Gasconade Street — Reside on Farm Yes [ ] No [ ]

3. NAME OF DECEASED (Type or print): First Myslinska, Middle Sister Mary Bertha, Last O. S. F.

4. DATE OF DEATH: Month January, Day 11, Year 1959

5. SEX: F.
6. COLOR OR RACE: White
7. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: August 13, 1891
9. AGE (In years last 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): Domestic
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and state or country): Poland, Europe
12. CITIZEN OF WHAT COUNTRY? USA.

13a. FATHER'S NAME: Francis Myslinski
13b. MOTHER'S MAIDEN NAME: Helen Dymon
14. NAME OF HUSBAND OR WIFE:

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.
17. INFORMANT: Mother Constance — Address: 3419 Gasconade St.

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) Coronary Thrombosis
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) HSHD HCVD
DUE TO (c) Diabetes Mellitus
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)
260X

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

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 July 1958, to Jan 1959 and last saw her alive on Jan 1959
Death occurred at 8:30a on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE [illegible] (Degree or title) MD
22b. ADDRESS 4075 S. Grand
22c. DATE SIGNED 1/12/59

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 1/13/59
23c. NAME OF CEMETERY OR CREMATORY: Villa St Joseph
23d. LOCATION (City, town, or county) (State): Ferguson Mo

24. FUNERAL DIRECTOR: Central Und Co — ADDRESS: 1841 Cass ave
25. DATE RECD. BY LOCAL REG.: JAN 12'59
26. REGISTRAR'S SIGNATURE: Carl Smith MD MDC

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

PS. 2-7370 1-3 6-6

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 J M Rister

Licensed Embalmer No. 3980

P. O. Address St Louis, M

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.