Health, Welfare Public Service

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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-003657
STATE FILE NUMBER

FILED FEB 11 1959 Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 51

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: ST. LOUIS — Inside Limits: Yes ☒ No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: JEWISH HOSP. — Length of stay in 1b: 3 DAYS

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MISSOURI — COUNTY: ST. LOUIS
c. CITY OR TOWN: LEMAY 4000 — Inside Limits: Yes ☐ No ☒
d. STREET ADDRESS (If outside, give location): 3617 PARK CREST AVE — Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First: ANTOINETTE — Middle: — Last: WOJCIECHOWSKI

4. DATE OF DEATH: Month: JAN. — Day: 3 — Year: 1959

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: APRIL 29 1886
9. AGE (In years last birthday): 72 — 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): HOUSE WORK
10b. KIND OF BUSINESS OR INDUSTRY: AT HOME
11. BIRTHPLACE (City and state or country): POLAND
12. CITIZEN OF WHAT COUNTRY?: U-S-A

13a. FATHER'S NAME: —
13b. MOTHER'S MAIDEN NAME: —
14. NAME OF HUSBAND ~~OR WIFE~~: STEFAN WOJCIECHOWSKI

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.: NONE
17. INFORMANT: IRENE LAKNESS — Address: 3617 PARK CREST DR.

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): Carcinoma of the Stomach
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c): 151X
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): Metastases to lungs & liver
19. WAS AUTOPSY PERFORMED? YES ☐ 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 April 30, 1958 to ____ and last saw her ~~him~~ alive on Jan 3, 1959
Death occurred at 8:30 A.m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: Michael W. Karl (Degree or title) MD.
22b. ADDRESS:
22c. DATE SIGNED: 1/4/59

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE: JAN. 5 1959
23c. NAME OF CEMETERY OR CREMATORY: CALVARY CEM.
23d. LOCATION (City, town, or county) (State): ST. LOUIS Mo

24. FUNERAL DIRECTOR: Thomas Kutis — ADDRESS: 2906 Gravois
25. DATE RECD. BY LOCAL REG.: JAN 5 '59
26. REGISTRAR'S SIGNATURE: J. Carl Smith M.D. M.D.
(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.

Res. 6316 [illegible] 1-7578

To 9-4037

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 C Dill

Licensed Embalmer No. 4347

P. O. Address 2906 Travis

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.