

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-007693

STATE FILE NUMBER

FILED MAR 2 1959

Registration District No.

Primary Registration District No.

Registrar No. 1596

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-57

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1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Missouri</i> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>St. Louis</i>	Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <i>St. Louis</i>	Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>4176 Farlin Ave.</i>	Length of stay in 1b	d. STREET ADDRESS <i>4176 Farlin Ave.</i>	(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <i>WALTER F. TAJKOWSKI</i>			4. DATE OF DEATH Month Day Year <i>February 13, 1959</i> <i>Feb. 13, 1959</i>	
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5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2. DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 20, 1876</i>	9. AGE (in years last birthday) <i>82</i>	10. FUNDING YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Cabinet Maker</i>	10b. KIND OF BUSINESS OR INDUSTRY *****	11. BIRTHPLACE (City and state or country) <i>Poland</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
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13a. FATHER'S NAME <i>Konstanty Tajkowski</i>	13b. MOTHER'S MAIDEN NAME <i>Teofila Santorska</i>	14. NAME OF HUSBAND OR WIFE <i>Eugenia Tajkowski</i>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>no none</i>	16. SOCIAL SECURITY NO. <i>492-01-2307a</i>	17. INFORMANT Address <i>Wanda Podgorny 4176 Farlin Avenue.</i>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Cardiac Failure</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2 1/2 hrs.</i>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <i>Acute rheumatic Carditis</i>		<i>5 yrs.</i>
	DUE TO (c) <i>Heart block 422.1</i>		
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"/> 2	

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.) ITEM <i>4</i> CORRECTED BY AFFIDAVIT OF <i>Funeral Director</i> <i>3-10-59</i>
20c. TIME OF INJURY Hour Month, Day, Year 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
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21. I attended the deceased from <i>5/29/57</i> to <i>2/13/59</i> and last saw ^{her} him alive on <i>2/13/59</i> Death occurred at <i>100 p.m.</i> on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>W. Crapuchne</i> (Degree or title)	22b. ADDRESS <i>1901 Madison St.</i>	22c. DATE SIGNED <i>2/14/59</i>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>2/16/59</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Calvary Cemetery</i>	23d. LOCATION (City, town, or county) (State) <i>St. Louis, Missouri</i>
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24. FUNERAL DIRECTOR <i>JOHN STYGAR & SON</i> ADDRESS <i>5541 RIVERVIEW BLVD.</i>	25. DATE RECD. BY LOCAL REG. <i>FEB 15 '59</i>	26. REGISTRAR'S SIGNATURE <i>Earl Smith. M.D.</i>
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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. R. P. [Signature]*

Licensed Embalmer No. *56411*

P. O. Address *H. K. [Signature]*

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.