

Health,  
Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-011119

STATE FILE NUMBER  
2 2634

Registration District No. LEU APR 6 1959 Primary Registration District No. Registration No.

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5b

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>St. Louis</b>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Florissant 4051</b>	Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Louis Children's</b>		d. STREET ADDRESS (If outside, give location) <b>865 Loyola</b>	
Length of stay in lb <b>4mos</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <b>KIKKY</b> Middle <b>Lawrence</b> Last <b>Danko Lapczuk</b>			4. DATE OF DEATH Month <b>Mar.</b> Day <b>14,</b> Year <b>1959</b>		
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5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 3, 1958</b>	9. AGE (In years last birthday) <b>9</b>	IF UNDER 1 YEAR Months <b>9</b> Days	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	11. BIRTHPLACE (City and state or country) <b>St. Louis, Mo</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S. A.</b>
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13a. FATHER'S NAME <b>Roman Peter Lapczuk</b>	13b. MOTHER'S MAIDEN NAME <b>Catherine DuValeus</b>	14. NAME OF HUSBAND OR WIFE <b>None</b>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or name of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT <b>Jane Henrichsen-500 S.Kingshighway</b>	Address
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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) <b>Chronic congestive failure</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 mos.</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause lost.	DUE TO (b) <b>Cong. heart disease - IV septal defect</b>		<b>life</b>
	DUE TO (c) <b>754.2</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Hx. of correction of pre-ductal aortic coarctation at age 1 mo.</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input 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.)
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20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	20d. INJURY OCCURRED WHILE AT <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 <b>FLORISSANT, MO.</b>	COUNTY	STATE
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21. I attended the deceased from <b>11-15-58</b> to <b>3-14-59</b> and last saw her alive on <b>3-14-59</b> Death occurred at <b>10:17pm</b> m on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE (Degree or title) <b>Richard H. Smith, M.D.</b>	22b. ADDRESS <b>500 S. Kingshighway</b>	22c. DATE SIGNED <b>3-14-59</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>	23b. DATE <b>MARCH 16, 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>SACRED HEART</b>	23d. LOCATION (City, town, or county) (State) <b>FLORISSANT, MO.</b>
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24. FUNERAL DIRECTOR <b>THE FLORISSANT MORTUARY,</b>	ADDRESS <b>FLORISSANT, MO.</b>	25. DATE RECD. BY LOCAL REG. <b>MAR 16 '59</b>	26. REGISTRAR'S SIGNATURE <b>Richard H. Smith, M.D.</b>
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(Licensed Embalmer's Statement on Reverse Side)

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 *Gene A. Hutchins* .....

Licensed Embalmer No. *4966* .....  
P. O. Address *Flourissant, La.* .....

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.