

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-015183

STATE FILE NUMBER

Registrar 2 2806

300  
1-57

3

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_

1. PLACE OF DEATH  
a. COUNTY \_\_\_\_\_

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)  
a. STATE MISSOURI COUNTY \_\_\_\_\_

b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS Mo Inside Limits Yes  No

c. CITY OR TOWN ST. LOUIS Inside Limits Yes  No

c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 2202 Missouri Length of stay in 1b \_\_\_\_\_

d. STREET ADDRESS (If outside, give location) 2202 Missouri Reside on Farm Yes  No

3. NAME OF DECEASED First Middle Last  
(Type or print) MAXMILLIAN JASKIEWICZ

4. DATE OF DEATH Month Day Year  
MAR. 17 1959

5. SEX MALE 6. COLOR OR RACE WHITE 7. MARRIED  NEVER MARRIED  WIDOWED  DIVORCED

8. DATE OF BIRTH MAR. 10 1877 9. AGE (In years last birthday) 82 10. FUNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED BLACKSMITH 10b. KIND OF BUSINESS OR INDUSTRY \_\_\_\_\_ 11. BIRTHPLACE (City and state or country) POLAND 12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME ALEXANDER JASKIEWICZ 13b. MOTHER'S MAIDEN NAME UNKNOWN 14. NAME OF HUSBAND OR WIFE CAROLINE JASKIEWICZ

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No 16. SOCIAL SECURITY NO. (A) 17. INFORMANT Address JOSEPH JASKIEWICZ 2614 LEMP

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) Sept Arteriosclerotic heart disease  
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) \_\_\_\_\_  
DUE TO (c) 420.0  
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) \_\_\_\_\_

INTERVAL BETWEEN ONSET AND DEATH 1 year

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  NOT WHILE WORK  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 Jan 1958 to 1959 and last saw her/him alive on March 9 - 1959  
Death occurred at 4am on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Ralph Berglund 22b. ADDRESS 32038 Grand 22c. DATE SIGNED 3/18/59

23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL 23b. DATE MAR. 20 1959 23c. NAME OF CEMETERY OR CREMATORY RESURRECTION CEM. 23d. LOCATION (City, town, or county) (State) ST. LOUIS Mo

24. FUNERAL DIRECTOR ADDRESS Thomas Luter 2906 Garois 25. DATE RECD. BY LOCAL REG. MAR 19 '59 26. REGISTRAR'S SIGNATURE Roan Smith, M.D.

mgb.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

1132-336

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 Eleanor Province

Licensed Embalmer No. 3403

P. O. Address Jennings

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.