

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-015581

STATE FILING NUMBER 3396  
REGISTRATION NUMBER

FILED APR 24 1959

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 <b>Missouri</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		c. CITY OR TOWN <b>St. Louis</b>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>4004 Marcus</b>		d. STREET ADDRESS (If outside, give location) <b>4004 Marcus</b>	
Length of stay in lb		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Rachupka</b> Last			4. DATE OF DEATH Month <b>4</b> Day <b>3</b> Year <b>59</b>		
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-1-1882</b>	9. AGE (In years report birthday) <b>76</b>	IF UNDER 1 YEAR Month <b>11</b> Day <b>3</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Poland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>
13a. FATHER'S NAME <b>Unknown</b>		13b. MOTHER'S MAIDEN NAME <b>Unknown</b>		14. NAME OF HUSBAND OR WIFE <b>Victor Rachupka</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Mrs. Anna Kennedy 4004 Marcus</b>	

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>Cerebral Hemorrhage</b>			INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Arteriosclerotic Cardio Vas disease</b>		
	DUE TO (c) <b>422.1</b>		<b>10 yrs</b>

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)  
**Diabetes Mellitus - and Previous Cerebral Hemorrhage**

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.)
---	--

20c. TIME OF INJURY Hour 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
---	--	--	---

21. I attended the deceased from Death occurred at <b>1957</b> to <b>Apr 2 1959</b> and last saw her alive on <b>Apr 2 1959</b> <b>SA</b> on the date stated above; and to the best of my knowledge, from the causes stated.
---

22a. SIGNATURE (Degree or title) <b>Dr. G N Lerman M.D.</b>	22b. ADDRESS <b>4126 S Sheer</b>	22c. DATE SIGNED <b>4/6/59</b>
--	-------------------------------------	-----------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>4-7-59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Calvary</b>	23d. LOCATION (City, town, or county) (State) <b>St. Louis Missouri</b>
--	----------------------------	--	--

24. FUNERAL DIRECTOR ADDRESS <b>ST. LOUIS FUNERAL HOME 2205 ST. LOUIS AVE</b>	25. DATE RECD. BY LOCAL REG. <b>APR 6 '59</b>	26. REGISTRAR'S SIGNATURE <b>Mr. Paul Smith. M.D.</b>
--	--	--

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

Deal & Associates 4126a St. Louis FOS-7140

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 Stanley H. Dyer

Licensed Embalmer No. 4190  
P. O. Address St. L.

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.