

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-018921
State File No. 2 5221
Registrar's No.

FILED JUN 15 1959

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY			
b. CITY (If outside corporate limits, write RURAL and give town) St. Louis		c. LENGTH OF STAY (in this place)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis			
d. FULL NAME OF HOSPITAL OR INSTITUTION LUTHERAN HOSPITAL				d. STREET ADDRESS (If rural, give location) 2710 Lemp Ave.			
3. NAME OF DECEASED (Type or Print) a. (First) ANNIE		b. (Middle)		c. (Last) BARTKIEWICZ		4. DATE OF DEATH (Month) (Day) (Year) May, 29, 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH May, 19, 1875	9. AGE (In years last birthday) 84	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Poland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Joseph Bandur			13b. MOTHER'S MAIDEN NAME Agatha ?		14. NAME OF HUSBAND OR WIFE Adam Bartkiewicz		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Adam Bartkiewicz 2710 Lemp Ave.			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cardiac Decongenitation			INTERVAL BETWEEN ONSET AND DEATH 4 days
				ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Chronic Myocardial Disease			
				DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 422.2			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from May 8th , 1959, to May 29 , 1959, that I last saw the deceased alive on May 29th , 1959, and that death occurred at 5:00 A.M. , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) Paul B. Webb, M.D.				23b. ADDRESS 1915^a Sedgeway		23c. DATE SIGNED 6/1/59	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 6/2/59		24c. NAME OF CEMETERY OR CREMATORY Resurrection Cemetery		24d. LOCATION (City, town, or county) (State) St. Louis County, Mo.	
DATE REC'D BY LOCAL REG. JUN 1 '59		REGISTRAR'S SIGNATURE Carl Smith, M.D.		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS CHULICK UND. CO. 1722 S. Jefferson			

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
Student Embalmer

Signed *Herbert J. Gan Jr.*

Licensed Embalmer No. *4800*

P. O. Address *Kirkwood 27, Mo.*

Note: The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his **OWN HANDWRITING**. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.