

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-019992  
STATE FILE NUMBER

FILED JUN 9 1959 Registration District No. **317** Primary Registration District No. **550-590** Registrar's No. **1506**

300  
1-57  
4001

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Illinois</b> b. COUNTY <b>Illinois</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Rural Wellston</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Des Plaines</b> 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>St. Vincent's Hosp.</b>		Length of stay in lb <b>6 yrs. 9 mos.</b>	d. STREET ADDRESS (If outside, give location) <b>353 N. River Road</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>PRESEPIA</b> , Middle <b>SISTER</b> , Last <b>Latuwnik</b>			4. DATE OF DEATH Month <b>June</b> , Day <b>1</b> , Year <b>1959</b>		
5. SEX <b>Female</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>8-11-96</b>		9. AGE (In years last birthday) <b>62</b> IF UNDER 1 YEAR: Months <b>9</b> IF UNDER 24 HRS.: Hours <b>9</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Religious- Holy Family of Nazareth</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Chicago, Illinois</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13a. FATHER'S NAME <b>Joseph Latuwnik</b>		13b. MOTHER'S MAIDEN NAME <b>Antoinette Kulesza</b>		14. NAME OF HUSBAND OR WIFE	
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 <b>Records of St. Vincent's Hospital</b> Address	

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>Acute Coronary Thrombosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 min.</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Hypertensive Cardio Vascular Disease</b>	<b>Years</b>
	DUE TO (c) <b>Diabetes Mellitus</b>	<b>Years</b>
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 checked="" 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.) <b>260X</b>	
20c. TIME OF INJURY Hour <b>9:45</b> Month, Day, Year <b>6-1-59</b> a.m. p.m.		
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION <b>Des Plaines Ill.</b> COUNTY STATE

21. I attended the deceased from <b>8-27-52</b> to <b>6-1-59</b> and last saw her/him alive on <b>6-1-59</b> Death occurred at <b>9:45 A.M.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.		
22a. SIGNATURE <b>J. Bauer MD</b> (Degree or title)	22b. ADDRESS <b>7301 St. Charles Rock Rd.</b>	22c. DATE SIGNED <b>6/1/59</b>

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>6/2/59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Holy Family convent</b>	23d. LOCATION (City, town, or county) (State) <b>Des Plaines Ill.</b>
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24. FUNERAL DIRECTOR <b>Callen Kelly</b> ADDRESS <b>7267 Natural Bridge</b>	25. DATE RECD. BY LOCAL REG. <b>6-2-59</b>	26. REGISTRAR'S SIGNATURE <b>J. B. Murphy M.D.</b>
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 *James A. Lamm* .....  
Licensed Embalmer No. *414* .....  
P. O. Address *St. Louis* .....

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.