

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-023300

STATE FILE NUMBER

FILED JUN 24 1959 Registration District No. Primary Registration District No. Registrar's No. 2-5647

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis, Missouri</u> Inside-Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>St. Louis</u> Inside-Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Bethesda Hosp.</u> Length of stay in 1b		d. STREET ADDRESS (If outside, give location) <u>4567a Adelaide Ave.</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Teofil Przetak</u>			4. DATE OF DEATH Month Day Year <u>June 12, 1959</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 28, 1888</u>
9. AGE (In years last birthday) <u>71</u>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Patent Maker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Steel</u>	11. BIRTHPLACE (City and state or country) <u>Poland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>Anthony Przetak</u>	
14. MOTHER'S MAIDEN NAME <u>Catherine Gawlak</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes Jan. 24, 1911</u>	
16. SOCIAL SECURITY NO. <u>355-10-5216</u>		17. INFORMANT Address <u>Edwin Przetak, 4567 Adelaide Avenue</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> DUE TO (b) <u>arteriosclerotic Heart Disease</u> DUE TO (c) <u>Arteriosclerosis, Cerebral.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I:(a) <u>4200</u>			INTERVAL BETWEEN ONSET AND DEATH <u>86 hrs.</u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input checked="" 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 Month, Day, Year <u>5:00 P. M.</u>	
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, etc.)	
20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from <u>Jan 17, 1955</u> to <u>June 12, 1958</u> and last saw her alive on <u>June 11, 1959</u> Death occurred at <u>509 A</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Joseph O. Carney MD</u>		22b. ADDRESS <u>906 Olive St</u>	
22c. DATE SIGNED <u>6-13-59</u>		23a. BURIAL, CREMATION, REMOVAL (Specify)	
23b. DATE <u>June 15, 1959</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>	
23d. LOCATION (City, town, or county) (State) <u>St. Louis, Missouri</u>		24. FUNERAL DIRECTOR ADDRESS <u>JOHN STYGAR & SON - 5541 RIVERVIEW BLVD.</u>	
25. DATE RECD. BY LOCAL REG. <u>JUN 13 59</u>		26. REGISTRAR'S SIGNATURE <u>Earl Smith, M.D.</u>	

(Licensed Embalmer's Statement on Reverse Side)

Doctor, coroner, etc. MUST use only standard nomenclature in item 18. Diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes. USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE.

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.....
Will T. Foster

Licensed Embalmer No. 390

P. O. Address *St. Louis*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.