

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-023346
State File No.

FILED JUL 1 1959

Registrar No. 5691

BIRTH NO.		REG. DIST. NO.		PRIMARY REG. DIST. NO.		Registrar No. 5691	
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 or township) St. Louis		c. LENGTH OF STAY (In this place) 10 yrs.		c. CITY OR TOWN St. Louis		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION 4 Little Sisters of the Poor				e. STREET ADDRESS (If rural, give location) 3400 S. Grand Ave.			
3. NAME OF DECEASED (Type or Print) a. (First) Frank			b. (Middle) Romek			c. (Last) Romek	
4. DATE OF DEATH June 14, 1959		5. SEX Male <input type="radio"/>		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single <input type="radio"/>	
8. DATE OF BIRTH Dec. 16, 1884		9. AGE (In years last birthday) 74 yrs.		10. MONTHS 5		11. HOURS 28	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber			10b. KIND OF BUSINESS OR INDUSTRY Retired			11. BIRTHPLACE (City and State or Foreign Country) Lithuania	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME Mike Romek		13b. MOTHER'S MAIDEN NAME Paulina Bellas		14. NAME OF HUSBAND OR WIFE none	
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. 494-10-5055		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Sr. Marie Jean Supr. 3400 S. Grand 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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>Arteriosclerotic heart disease</i> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <i>Generalized arteriosclerosis</i> DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 420.0					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? <input checked="" type="checkbox"/> YES <input 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) <i>St. Louis, Mo.</i>			
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 <i>Jan, 1959</i> , to <i>6/14, 1959</i> , that I last saw the deceased alive on <i>6/12, 1959</i> , and that death occurred at <i>11:30 a.m.</i> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <i>P. Mezera M.D.</i>				23b. ADDRESS 8059 Watson Road		23c. DATE SIGNED 6/15/59	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 6/16/59		24c. NAME OF CEMETERY OR CREMATORY SS. Peter & Paul Cem		24d. LOCATION (City, town, or county) (State) St. Louis Mo.	
DATE REC'D BY LOCAL REG. JUN 15 1959		REGISTRAR'S SIGNATURE <i>Earl Smith M.D.</i>		25. FUNERAL DIRECTOR'S SIGNATURE John H. Gebken Sons		ADDRESS 2680 Gravois	

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

49
2/6/4

Earl Smith M.D.
John H. Gebken Sons
(Licensed Embalmer's Statement on Reverse Side)

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 *Robert F. Gebken*

Licensed Embalmer No. *4144*

P. O. Address *2630 Gravois Av*

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.