

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-023518

FILED JUL 1 1959

Registration District No. _____ Primary Registration District No. _____
STATE FILE NUMBER _____ Registry No. **5803**

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, give TOWNSHIP only) OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION DePaul		Length of stay in 1b.		d. STREET ADDRESS (If outside, give location) 1513 Benton	
				Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last
Peter Wencewicz

4. DATE OF DEATH Month Day Year
6-16-59

5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER-MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-1-1883	9. AGE (In years last birthday) 76	IF FUNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cabinet Maker	10b. KIND OF BUSINESS OR INDUSTRY American Fixtures	11. BIRTHPLACE (City and state or country) Poland	12. CITIZEN OF WHAT COUNTRY? U. S. A.
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13a. FATHER'S NAME Unknown	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Mary Wencewicz
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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. 494-10-1041	17. INFORMANT Address Helen Wencewicz 1513 Benton
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) **arteriosclerotic heart disease** INTERVAL BETWEEN ONSET AND DEATH **unknown**

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. }
DUE TO (b) _____
DUE TO (c) **420.0**

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)
Diabetes mellitus

19. WAS AUTOPSY PERFORMED?
YES NO

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.)
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20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE 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
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21. I attended the deceased from June 7, 1959 to June 16, 1959 and last saw her alive on 6-16-59 Death occurred at 10:45 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.		
22a. SIGNATURE (Name or title) D. H. Feller M.D.	22b. ADDRESS 2739 N. Grand	22c. DATE SIGNED 6-18-59

23a. BURIAL, CREMATION, REMOVAL, (specify) Burial	23b. DATE 6-19-59	23c. NAME OF CEMETERY OR CREMATORY Calvary	23d. LOCATION (City, town, or county) (State) St. Louis, Missouri
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24. FUNERAL DIRECTOR ADDRESS ST. LOUIS FUNERAL HOME 2205 St. Louis Ave.	25. DATE RECD. BY LOCAL REG. JUN 18 '59	26. REGISTRAR'S SIGNATURE Roald Smith, M.D. R.P.
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

638N. 20th

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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 *J. W. Dinkley*
Licensed Embalmer No. *3653*
P. O. Address *J. Lewis & Co*

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.