

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-023733

STATE FILE NUMBER

FILED JUN 26 1959 Registration District No. 317 Primary Registration District No. 500 Registrar's No. 1621

1. PLACE OF DEATH a. COUNTY ST. LOUIS		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 ELLISVILLE - MO.		c. CITY OR TOWN ST. LOUIS	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION SUNSET-SANITARIUM.		d. STREET ADDRESS (If outside, give location) 1803 No. MARKET-ST.	
3. NAME OF DECEASED (Type or print) First Middle Last PAUL - PETER - KULASINSKI.		4. DATE OF DEATH Month Day Year JUNE-15TH 1959	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH NOV. 30TH 1889
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED-STEVEDOR		10b. KIND OF BUSINESS OR INDUSTRY ILLINOIS-TERMINAL-R.R.	11. BIRTHPLACE (City and state or country) THORPE - WISC. 1
13a. FATHER'S NAME FELIX - KULASINSKI		13b. MOTHER'S MAIDEN NAME JULIA - ONECKI	14. NAME OF HUSBAND OR WIFE NEVER-MARRIED
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) NO NONE		16. SOCIAL SECURITY NO. RR #A.54654	17. INFORMANT Address <HIMSELF> PRE-ARRANGED-FUNERAL
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion			INTERVAL BETWEEN ONSET AND DEATH Inst.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Arteriosclerosis heart disease			?
DUE TO (c) Generalized arteriosclerosis			?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Cerebral arteriosclerosis 420.0			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 a.m. p.m.			
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT 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
21. I attended the deceased from 1 Oct. 58 to 6/11/59 and last saw him alive on 6/11/59 Death occurred at 4:40 P. m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) J. H. Zurett M.D.		22b. ADDRESS 1021 E. Duquesne Parkwood, LL, MO	22c. DATE SIGNED 6/16/59
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	23b. DATE JUNE-17TH 1959	23c. NAME OF CEMETERY OR CREMATORY CALVARY-CEMETERY	23d. LOCATION (City, town, or county) (State) ST. LOUIS MO.
24. FUNERAL DIRECTOR ADDRESS Brockland Und. G. - 1827-HOGAN-ST.		25. DATE RECD. BY LOCAL REG. 6-16-59	26. REGISTRAR'S SIGNATURE John C. Murphy M.D.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *Oliver R. Jackson*

Licensed Embalmer No. *4877*

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.