

# RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-026325

FILED VS AUG 11 1959

Registration District No. 316 Primary Registration District No.      Registrar's No. 310

STATE FILE NUMBER

DED

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <b>St. Francois</b>	a. STATE <b>Missouri</b> b. COUNTY <b>City of St. Louis</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Francois Township</b>	Length of stay in 1b <b>2 Y; 2M; 24D</b>	c. CITY OR TOWN <b>St. Louis</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>State Hospital No. 4</b>	Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>1213 Clinton</b>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print)	First <b>DORINDA</b>	Middle <b>FIUJARSKI</b>	Last <b>FIUJARSKI</b>	4. DATE OF DEATH	Month <b>July</b>	Day <b>28</b>	Year <b>1959</b>
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5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 14, 1898</b>	9. AGE (last birthday) <b>61</b>	IF UNDER 1 YEAR Months <b>5</b> Days <b>14</b>	IF UNDER 24 HR Hours <b>    </b> Min. <b>    </b>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House work</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>St. Louis, Missouri</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
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13a. FATHER'S NAME <b>David Winton</b>	13b. MOTHER'S MAIDEN NAME <b>Emma Jerome</b>	14. NAME OF HUSBAND OR WIFE <b>Frank Fiujarski</b>
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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) <b>No</b>	16. SOCIAL SECURITY NO. <b>Unknown</b>	17. INFORMANT <b>Records, State Hospital No. 4, Farmington, Mo.</b>
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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:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	<b>Bronchial pneumonia</b>	<b>10 das.</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Inanition</b>	<b>Abt. 2 mos.</b>
	DUE TO (c) <b>Psychosis</b>	<b>Abt. 3 yrs.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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.)
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20c. TIME OF INJURY Hour <b>    </b> Month, Day, Year <b>    </b>	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 bldg., etc.)	20f. CITY, TOWN, OR LOCATION <b>    </b> COUNTY <b>    </b> STATE <b>    </b>
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21. I attended the deceased from <b>June 30, 1959</b> to <b>July 28, 1959</b> and last saw her alive on <b>July 28, 1959</b> Death occurred at <b>2:05 P. M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE <i>John A. Brennan, M.D.</i> (Degree or title)	22b. ADDRESS <b>State Hospital No. 4 Farmington, Missouri</b>	22c. DATE SIGNED <b>7-29-59</b> (State)
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>8-3-59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Washington Univ. Anat. Dept.</b>	23d. LOCATION (City, town, or county) <b>St. Louis, Mo.</b>
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24. FUNERAL DIRECTOR <b>Via Cozean Funeral Home, Farmington, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>Aug 7, 1959</b>	26. REGISTRAR'S SIGNATURE <i>Gather Rudloff</i>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed \_\_\_\_\_

Licensed Embalmer No. \_\_\_\_\_

P. O. Address: \_\_\_\_\_

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.