

# RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

**FILED VS JUL 24 1959**

**2 6515-59-027081**  
STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

INDEXED

<b>1. PLACE OF DEATH</b> a. COUNTY _____  b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis, Missouri</u> Length of stay in 1b _____  c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>De Paul Hospital</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> COUNTY _____  c. CITY OR TOWN <u>St. Louis</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  d. STREET ADDRESS (If outside, give location) <u>1931a N. Florissant</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>				
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>Jake Posenuk</u>			<b>4. DATE OF DEATH</b> Month Day Year <u>July 9 1959</u>					
<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. Married</b> <input checked="" type="checkbox"/> <b>Never Married</b> <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>5/8/1889</u>	<b>9. AGE (last birthday)</b> <u>70</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Butcher</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Retired</u>		<b>11. BIRTHPLACE</b> (City and state or country) <u>Russia</u>		<b>12. CITIZEN OF WHAT COUNTRY</b> <u>U. S. A.</u>		
<b>13a. FATHER'S NAME</b> <u>Wasil Posechnik</u>			<b>13b. MOTHER'S MAIDEN NAME</b> <u>Unknown</u>			<b>14. NAME OF HUSBAND OR WIFE</b> <u>Tillie Posenuk</u>		
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>			<b>16. SOCIAL SECURITY NO.</b> <u>488-32-0156</u>			<b>17. INFORMANT</b> Address <u>Tillie Posenuk, 1931a N. Florissant</u>		
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of esophagus</u>  Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. ) DUE TO (b) _____ DUE TO (c) _____  PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>none</u>						INTERVAL BETWEEN ONSET AND DEATH <u>don't know</u>		
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)				
<b>20c. TIME OF INJURY</b> Hour _____ a.m. _____ p.m. Month, Day, Year _____		<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> <b>NOT WHILE AT WORK</b> <input type="checkbox"/>						
<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		<b>20f. CITY, TOWN, OR LOCATION</b> _____		COUNTY _____		STATE _____		
<b>21. I attended the deceased from</b> <u>1-2-59</u> to <u>7-9-59</u> and last saw <sup>her</sup> him alive on <u>7-8-59</u> Death occurred at <u>1:30 AM</u> on the date stated above, and to the best of my knowledge, from the causes stated.								
<b>22a. SIGNATURE</b> (Degree or title) <u>Walter H. Sporeman M.D.</u>				<b>22b. ADDRESS</b> <u>1515 St. Louis</u>			<b>22c. DATE SIGNED</b> <u>7-10-59</u>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>23b. DATE</b> <u>July 13, 1959</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Calvaru Cemeteru</u>		<b>23d. LOCATION</b> (City, town, or county) (State) <u>St. Louis Missouri</u>		
<b>24. FUNERAL DIRECTOR</b> ADDRESS <u>JOHN STYGAR &amp; SON - 554T RIVERVIEW BLVD.</u>				<b>25. DATE RECD. BY LOCAL REG.</b> <u>JUL 10 59</u>		<b>26. REGISTRAR'S SIGNATURE</b> <u>Keaf Smith, M.D.</u>		

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 *J. M. Rister*

Licensed Embalmer No. 3980

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.