

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS AUG 18 1959

59-030304

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **2 7305** STATE FILE NUMBER

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| 1. PLACE OF DEATH a. COUNTY _____ | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY _____ | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis, Mo.</u> | | c. CITY OR TOWN <u>St. Louis, Mo.</u> | |
| Length of stay in 1b <u>10 Yrs, 3 Mo, 11 days</u> | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Louis State</u> | | d. STREET ADDRESS (If outside, give location) <u>8683 Oriole Av.</u> | |
| Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |

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| 3. NAME OF DECEASED (Type or print) First <u>ANNA</u> Middle <u>CEGLINSKI</u> Last _____ | | | 4. DATE OF DEATH Month <u>August</u> Day <u>5</u> Year <u>1959</u> | | | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>11-2-1900</u> | 9. AGE (last birthday) <u>58 yrs.</u> | IF UNDER 1 YEAR Months _____ Days _____ | IF UNDER 24 HR Hours _____ Min. _____ |

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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife formerly</u> | 10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u> | 11. BIRTHPLACE (City and state or country) <u>Pittsburgh, Pa.</u> | 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> |
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| 13a. FATHER'S NAME <u>? Karpinski</u> | 13b. MOTHER'S MAIDEN NAME <u>?? UNKNOWN</u> | 14. NAME OF HUSBAND OR WIFE <u>Frank Ceglinski</u> |
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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) <u>NO</u> | 16. SOCIAL SECURITY NO. <u>NONE</u> | 17. INFORMANT <u>FRANK-CEGLINSKI-8683-ORIOLE-AV</u> |
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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) <u>Bronchopneumonia</u> | | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | DUE TO (b) <u>Cerebral Vascular Accident</u> DUE TO (c) <u>Generalized Arteriosclerosis</u> | |

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| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Neurosyphilis (General Paresis)</u> | 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 |
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| 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 _____ a.m. _____ p.m. | Month, Day, Year _____ |
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| 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 COUNTY _____ STATE _____ |
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21. I attended the deceased from Apr. 25, 1949 to Aug. 5, 1959 and last saw ^{her}~~him~~ alive on Aug. 5, 1959
 Death occurred at 8:30 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.

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| 22a. SIGNATURE <u>A. F. Heusler M.D.</u> | 22b. ADDRESS <u>5400 Arsenal St.,</u> | 22c. DATE SIGNED <u>8-5-59</u> |
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| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | 23b. DATE <u>AUG. 7TH 1959</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>CALVARY-CEMETERY</u> | 23d. LOCATION (City, town, or county) (State) <u>ST. LOUIS MO.</u> |
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| 24. FUNERAL DIRECTOR <u>Brookland Und. Co. 1827-HOGAN-ST.</u> | 25. DATE REGD. BY LOCAL REG. <u>AUG 6 '59</u> | 26. REGISTRAR'S SIGNATURE <u>Loard Smith M.D.</u> |
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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

Robert M. Murray

Licensed Embalmer No. 3749

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.