

FRI MORNING 9:00 AM - 12:00 PM
URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH
FILED VS SEP 22 1959

59-034093

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **2 8396**

ENDED

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>		Length of stay in 1b <u>50 YRS.</u>		c. CITY OR TOWN <u>ST. LOUIS</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ST. LOUIS CITY HOSP. #1.</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>2112 A. BLAIR - AV.</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>ANTOINETTE</u> Middle _____ Last <u>MICHALAK</u>				4. DATE OF DEATH Month <u>SEPT.</u> Day <u>10,</u> Year <u>1959</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>12-6-1891</u>	9. AGE (last birthday) <u>67 YRS.</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE-WORK</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (City and state or country) <u>POLAND</u>		12. CITIZEN OF WHAT COUNTRY <u>POLAND</u>
13a. FATHER'S NAME <u>JOSEPH - ORZEL</u>			13b. MOTHER'S MAIDEN NAME <u>ANNA - GLAIZER</u>		14. NAME OF HUSBAND OR WIFE <u>STANISLAW - MICHALAK</u> <i>(decd.)</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u> <u>NONE</u>		16. SOCIAL SECURITY NO. <u>489-07-5248A</u>		17. INFORMANT Address <u>FLORISSANT. MO.</u> <u>STELLA - MEGHAY = 160 - ST. LUKE - DRIVE</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>pneumonitis</u> DUE TO (b) <u>congestive failure</u> <u>3 wks.</u> DUE TO (c) <u>arteriosclerotic heart disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>420.0</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							
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.)			
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____	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
21. I attended the deceased from <u>8/18/59</u> to <u>9/10/59</u> and last saw her/him alive on <u>9/10/59</u> Death occurred at <u>5:30 a.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>Robert K. Lane</u> (Degree or title)				22b. ADDRESS <u>1515 LAFAYETTE AVE.</u>		22c. DATE SIGNED <u>9/10/59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>SEPT. 12 - 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>CALVARY - CEMETERY</u>		23d. LOCATION (City, town, or county) <u>ST. LOUIS</u>		(State) <u>MO.</u>	
24. FUNERAL DIRECTOR <u>Brookland Und. G. 1827 - HOGAN - ST.</u> ADDRESS			25. DATE RECD. BY LOCAL REG. <u>SEP 11 '59</u>		26. REGISTRAR'S SIGNATURE <u>Robert Smith, M.D.</u>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

R.S.

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 John J. Haines

Licensed Embalmer No. 4108

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.