

**URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**  
**FILED VS OCT 19 1959**

**59-037887**

STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's **2 9187**

RECEIVED  
DOCUMENT  
MEDICAL CERTIFICATION  
BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo</b> b. COUNTY		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS Mo</b>		Length of stay in 1b	c. CITY OR TOWN <b>ST. LOUIS</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>5701 POTOMAC</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>5701 POTOMAC</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>RAY</b> Middle <b>MOCHISKY</b> Last			4. DATE OF DEATH Month <b>OCT.</b> Day <b>5</b> Year <b>1959</b>		
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>FEB. 4 1906</b>	9. AGE (last birthday) <b>53</b>	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) <b>DRILL PRESS OPERATOR</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>STYLECRAFT MFG. Mo</b>		11. BIRTHPLACE (City and state or country) <b>U.S.A.</b>	
13a. FATHER'S NAME <b>JOSEPH MOCHISKY</b>		13b. MOTHER'S MAIDEN NAME <b>ELIZABETH FALINKA</b>		14. NAME OF HUSBAND OR WIFE <b>CELIA MOCHISKY</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)   (If yes, give war or dates of service) <b>YES W.W.II</b>		16. SOCIAL SECURITY NO. <b>494-10-9504</b>		17. INFORMANT Address <b>CELIA MOCHISKY 5701 POTOMAC</b>	
48. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b>					INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Cerebral Arteriosclerosis</b>					
DUE TO (c) <b>332x</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Arteriosclerotic Heart Disease &amp; Aneurysm of Aorta</b>				PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input 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 <b>March 14, 1959</b> to <b>Oct 5, 1959</b> and last saw <sup>her</sup> <del>him</del> <sup>live</sup> on <b>Oct 5, 1959</b> Death occurred at <b>Oct 5</b> <b>8:15</b> a.m. on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <b>Richard Ruder MD</b>			22b. ADDRESS <b>3207 S. Bond Ave</b>		22c. DATE SIGNED <b>10-6-59</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>		23b. DATE <b>OCT. 7 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>NATIONAL CEM.</b>		23d. LOCATION (City, town, or county) (State) <b>ST. LOUIS Mo</b>
GENERAL DIRECTOR <b>Thomas Hutes 2906 Grassie</b>		ADDRESS		25. DATE RECD. BY LOCAL REG. <b>OCT 6 '59</b>	26. REGISTRAR'S SIGNATURE <b>Coart Smith, M.D.</b> <b>mrb</b>

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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 Elean Province

Licensed Embalmer No. 3403

P. O. Address 7906 Granada

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.