

**JURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**59-042029**

**FILED VS. NOV 20 1959**

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. **210489** STATE FILE NUMBER

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>IMPERIAL</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>ALEXIAN BROS. Hosp.</b>				Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>R. R. 3</b>		
3. NAME OF DECEASED (Type or print) First <b>FRANK</b> Middle <b>JANSKY</b> Last				4. DATE OF DEATH Month <b>Nov.</b> Day <b>12</b> Year <b>1959</b>				
5. SEX <b>MALE</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>JAN. 23 1887</b>		
9. AGE (last birthday) <b>72</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>RETIRED OWNER</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>RESTAURANT</b>		11. BIRTHPLACE (City and state or country) <b>WISCONSIN</b>		12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>	
13a. FATHER'S NAME <b>BARTHOLOMEW JANSKY</b>			13b. MOTHER'S MAIDEN NAME <b>MARY BRUCHAR</b>			14. NAME OF HUSBAND OR WIFE <b>MABEL JANSKY (DEC'D)</b>		
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>496-12-5667</b>		17. INFORMANT <b>DONALD JANSKY, IMPERIAL Mo</b>		Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease</b>							INTERVAL BETWEEN ONSET AND DEATH <b>4 1/2</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ <b>420.0</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 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>1956</b> to <b>1959</b> and last saw <sup>her</sup> him alive on <b>11-11-59</b> Death occurred at <b>12:30 a.m.</b> on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <b>J. H. Orsly M.D.</b>				22b. ADDRESS <b>5203 Chippewa St. Mo</b>		22c. DATE SIGNED <b>11-14-59</b>		
23a. BURIAL CREMATION, REMOVAL (Specify) <b>REMOVAL</b>		23b. DATE <b>Nov. 14 1959</b>		23c. NAME OF CEMETERY OR CREMATORY <b>VALHALLA CEM. ST. LOUIS Mo</b>		23d. LOCATION (City, town, or county) (State)		
24. FUNERAL DIRECTOR <b>Thomas Kuter 2906 Gravis</b>		ADDRESS		25. DATE RECD. BY LOCAL REG. <b>NOV 14 1959</b>		26. REGISTRAR'S SIGNATURE <b>Roan Smith, M.D.</b>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

*hem*

**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 Eleanor Province

Licensed Embalmer No. 3403

P. O. Address 2906 9th

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.