

JURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH
FILED VS DEC 11 1959

59-042311

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's **811184**

1. PLACE OF DEATH a. COUNTY _____		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO. b. COUNTY _____	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Chronic Hosp.		d. STREET ADDRESS (If outside, give location) 1633 Helen - ST.	

3. NAME OF DECEASED (Type or print) First John Middle _____ Last Nowak			4. DATE OF DEATH Month 12 Day 1 Year 59		
---	--	--	---	--	--

5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 1-14-1886	9. AGE (last birthday) 73 YRS.	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	IF UNDER 24 HR Hours _____ Min. _____
-----------------------	----------------------------------	---	--------------------------------------	--	---	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CHIPPER	10b. KIND OF BUSINESS OR INDUSTRY AMERICAN-STEEL-FOUNDRY	11. BIRTHPLACE (City and state or country) Austria	12. CITIZEN OF WHAT COUNTRY U. S A
---	--	--	--

13a. FATHER'S NAME Anthony - NOWAK	13b. MOTHER'S MAIDEN NAME Maryanna - BASCZA	14. NAME OF HUSBAND OR WIFE Rose - NOWAK
--	---	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO	16. SOCIAL SECURITY NO. NONE	17. INFORMANT ROSE-NOWAK - 1633-HELEN-ST.	Address
---	--	---	---------

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) Pt. Middle Cerebral Artery Thrombosis - 6 days.		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Cerebral Arteriosclerosis	6 days.
	DUE TO (c) Generalized Arteriosclerosis	6 Days.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Terminal Bilat. Bronchopneumonia - 3 days.		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.) 332x
---	---	---

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 **11-25-59** to **12-1-59** and last saw her/him alive on **12-1-59**
 Death occurred at **9:05 p.m.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) John W. Beckham, M.D.	22b. ADDRESS 5800 Arsenal	22c. DATE SIGNED 12/2/59
--	-------------------------------------	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE DEC. 4 - 1959	23c. NAME OF CEMETERY OR CREMATORY CALVARY - CEMETERY	23d. LOCATION (City, town, or county) ST. LOUIS	(State) MO.
--	-----------------------------------	---	---	-----------------------

24. FUNERAL DIRECTOR Brockland Und. C. 1827-HOGAN-ST.	25. DATE RECD. BY LOCAL REG. DEC 3 1959	26. REGISTRAR'S SIGNATURE Coal Smith, M.D.
---	---	--

DOCUMENT

MEDICAL CERTIFICATION

BY BRIDAVIT OF

mrb

WEST 07

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 James D. Embury

Licensed Embalmer No. 36

P. O. Address St Louis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.