

**URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**  
**FILED VS DEC 21 1959**

'59 0 4 5 2 3 9

STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's **811290**

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</b>		Length of stay in 1b		c. CITY OR TOWN <b>St. Louis</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Deaconess</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>2543 Dodier</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Joseph</b> Middle <b>A.</b> Last <b>Bielicke</b>				4. DATE OF DEATH Month <b>12</b> Day <b>4</b> Year <b>59</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>12-22-1903</b>	9. AGE (last birthday) <b>55</b>	IF UNDER 1 YEAR Months <b>11</b> Days <b>12</b>	IF UNDER 24 HR Hours <b>12</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Tavern Operator</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>St. Louis, Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>
13a. FATHER'S NAME <b>Jacob Bielicke</b>			13b. MOTHER'S MAIDEN NAME <b>Josephine Gaszta</b>		14. NAME OF HUSBAND OR WIFE <b>Rose Sawicki</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>494-26-5827</b>		17. INFORMANT Address <b>Rose Bielicke 2543 Dodier</b>		
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>Reticulum Cell Sarcoma</b>							INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. ) DUE TO (b) _____ DUE TO (c) <b>200-0</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Agranulocytosis, Pneumonia</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>11/17/59</b> to <b>12/4/59</b> and last saw <sup>him</sup> <del>her</del> alive on <b>12/2/59</b> Death occurred at <b>12:02A</b> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <b>Robert W. Ramsey, M.D.</b>				22b. ADDRESS <b>25a S. Flourissant, Ferguson, Mo.</b>		22c. DATE SIGNED <b>12/5/59</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>12-7-59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Calvary</b>		23d. LOCATION (City, town, or county) <b>St. Louis, Missouri</b>			
24. FUNERAL DIRECTOR ADDRESS <b>ST. LOUIS FUNERAL HOME</b> <b>2205 St. Louis Ave.</b>			25. DATE RECD. BY LOCAL REG. <b>DEC 5 1959</b>		26. REGISTRAR'S SIGNATURE <b>Earl Smith, M.D.</b> <i>ES</i>		

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 Stanley H. Ripon

Licensed Embalmer No. 419

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.