

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

'59 0 4 5 5 9 7

FILED VS JAN - 4 1960

211565

STATE FILE NUMBER

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Mo</i> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>ST. LOUIS, MO.</i>		c. CITY OR TOWN <i>St Louis</i>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>ST. LOUIS CITY HOSP. #1.</i>		d. STREET ADDRESS (If outside, give location) <i>1449A Cass Ave</i>	

3. NAME OF DECEASED (Type or print) First Middle Last <i>KOSTANTI JASTRZEMSKI</i>			4. DATE OF DEATH Month Day Year <i>DECEMBER 12 1959</i>		
---	--	--	---	--	--

5. SEX <i>MALE</i>	6. COLOR OR RACE <i>WHITE</i>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <i>10-15-1891</i>	9. AGE (last birthday) <i>68</i>	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) <i>LABORER</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>ABC BAKING Co.</i>	11. BIRTHPLACE (City and state or country) <i>Poland</i>	12. CITIZEN OF WHAT COUNTRY <i>USA</i>
---	--	---	---

13a. FATHER'S NAME <i>RAYMOND Jastrzemski</i>	13b. MOTHER'S MARDEN NAME <i>Frances Koetka</i>	14. NAME OF HUSBAND OR WIFE <i>None</i>
--	--	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. <i>495-32-0319A</i>	17. INFORMANT <i>MARY Wiczorek</i>	Address <i>1449A Cass Ave.</i>
--	--	---------------------------------------	-----------------------------------

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) <i>Aspiration</i>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <i>Cerebral Thrombosis</i>	
DUE TO (c) <i>392x</i>		
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 checked="" type="checkbox"/> NO <input 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 Month, Day, Year p.m.	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 <i>November 21, 1959</i> to <i>December 12, 1959</i> and last saw her him alive on <i>December 12, 1959</i>	
Death occurred at <i>1:25 A.M.</i> on the date stated above, and to the best of my knowledge, from the causes stated.	

22a. SIGNATURE <i>Robert K. Lane M.D.</i>	(Degree or title)	22b. ADDRESS <i>1515 LAFAYETTE AVE.</i>	22c. DATE SIGNED <i>12-12-59</i>
--	-------------------	--	-------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	23b. DATE <i>12-15-59</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Mt. Olive</i>	23d. LOCATION (City, town, or county) (State) <i>St. Louis, Mo.</i>
--	------------------------------	--	--

24. FUNERAL DIRECTOR <i>Central Funeral Home</i>	ADDRESS <i>184 Cass Ave</i>	25. DATE RECD. BY LOCAL REG. <i>DEC 14 1959</i>	26. REGISTRAR'S SIGNATURE <i>Carl Smith, M.D.</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

J. M. Rister

Licensed Embalmer No. 3980

P. O. Address M. Lewis

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.