

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

'59 0 45 8 0 9

FILED VS. JAN 4 1960

211816

STATE FILE NUMBER

|   |   |  |   |
|---|---|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Mo.</b> b. COUNTY   |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>St. Louis</b>   |   | Length of stay in 1b   |   |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>Alexian Brothers Hosp</b>                                       |   | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>   |   |
| d. STREET ADDRESS<br><b>2525 Farra</b>  |   | Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>  |   |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <b>John</b> Middle <b>Ponus</b> Last  |   | 4. DATE OF DEATH<br>Month <b>Dec</b> Day <b>19</b> Year <b>1959</b>  |   |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b>  | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>          | 8. DATE OF BIRTH<br><b>Aug 29 1890</b>                        |
| 9. AGE (last birthday)<br><b>69</b>   |   | IF UNDER 1 YEAR<br>Months  | IF UNDER 24 HR.<br>Days Hours Min.                            |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Post Dispatch</b>                               |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Paper Handler</b>  | 11. BIRTHPLACE (City and state or country)<br><b>Poland</b>   |
| 12. CITIZEN OF WHAT COUNTRY<br><b>U. S. A.</b>  |   | 13a. FATHER'S NAME<br><b>Unknown</b>   |   |
| 13b. MOTHER'S MAIDEN NAME<br><b>Unknown</b>   |   | 14. NAME OF HUSBAND OR WIFE<br><b>Deceased</b>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give war or dates of service)<br><b>XXXXXX   XXXXXXXXXXX</b>        |   | 16. SOCIAL SECURITY NO.<br><b>488-01-0151A</b>   | 17. INFORMANT<br><b>Ed Ponus</b>                              |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:  |   | Address<br><b>3 801 N. 25th St.</b>  |   |
| IMMEDIATE CAUSE (a) <b>Carcinoma of Pancreas - metastases to Liver</b>  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>6 mos</b>   |   |
| DUE TO (b) <b>Arteriosclerosis Cordis &amp; Scler. Heart Disease</b>  |   | <b>3 to 5 yrs.</b>   |   |
| DUE TO (c) <b>Acute Pyelitis &amp; Hematuria</b>  |   | <b>3 mos.</b>  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br><b>157 *</b> |   | PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |   |
| 19. WAS AUTOPSY PERFORMED?<br>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<br>Hour a.m. p.m.<br>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>11/1/59</b> to <b>12/19/59</b> and last saw her alive on <b>12/19/59</b>                                      |   | Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.   |   |
| 22a. SIGNATURE<br><b>A. J. Crapner M.D.</b>   | (Degree or title)   | 22b. ADDRESS<br><b>1901 Redwood St</b>   | 22c. DATE SIGNED<br><b>12/21/59</b>                           |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 23b. DATE<br><b>12/22/59</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Calvary Cemetry</b>   | 23d. LOCATION (City, town, or county)<br><b>St. Louis Mo.</b> |
| 24. FUNERAL DIRECTOR<br><b>JOHN STYGAR &amp; SON - 5541 RIVERVIEW BLVD.</b>   |   | 25. DATE RECD. BY LOCAL REG.<br><b>DEC 21 1959</b>   | 26. REGISTRAR'S SIGNATURE<br><b>Earl Smith, M.D.</b>          |

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 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.