

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS DEC 23 1959

'59 0 4 5 9 8 1

STATE FILE NUMBER

211480

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

ENDED

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, Missouri</b>		Length of stay in 1b <b>ABOUT 30 YRS</b>	c. CITY OR TOWN <b>St. Louis, Missouri</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>St. Louis State Hospital</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>1227a S. 6th St.</b>	
3. NAME OF DECEASED (Type or print) First <b>MICHAEL</b> Middle <b>STANKA</b> Last <b>STANKA</b>			4. DATE OF DEATH Month <b>Dec.</b> Day <b>10,</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 checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>7-18-02</b>	9. AGE (last birthday) <b>57 YRS.</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>ELECTRICIAN</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>ELECTRICAL</b>	11. BIRTHPLACE (City and state or country) <b>DU, QUIN, ILL</b>		12. CITIZEN OF WHAT COUNTRY <b>U. S. A</b>
13a. FATHER'S NAME <b>STANISLAUS STANKA</b>		13b. MOTHER'S MAIDEN NAME <b>MARY PEACE</b>		14. NAME OF HUSBAND OR WIFE <b>NONE</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>NONE</b>		17. INFORMANT Address <b>JOSEPHA STANKA CHICAGO, ILL</b>	
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 <b>2 MOS.</b>
IMMEDIATE CAUSE (a) <b>Myocardial infarction</b>					
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Coronary heart disease, Syphillitis aortitis</b>					
DUE TO (c) <b>Pneumonia (Pul. emboli)</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>CBS assoc. with CNS lues (Meningoencephalitic) with psychosis</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.) <b>023 X</b>		
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>July 29, 1957</b> to <b>Dec. 10, 1959</b> and last saw <sup>her</sup> him alive on <b>Dec. 10, 1959</b> Death occurred at <b>10:00</b> a.m. on the date stated above, and to the best of my knowledge, from the causes stated. <b>L. N. McCullough, M.D.</b>					
22a. SIGNATURE <b>L. N. McCullough M.D.</b> (Degree or title)			22b. ADDRESS <b>5400 Arsenal St.</b>		22c. DATE SIGNED <b>12-10-59</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>	23b. DATE <b>2-14-59</b>	23c. NAME OF CEMETERY OR CREMATION <b>RESURRECTION</b>		23d. LOCATION (City, town, or county) (State) <b>ST. LOUIS COUNTY MO</b>	
24. FUNERAL DIRECTOR <b>HOWARD A. MICHEL</b> ADDRESS <b>5930 SOUTHWEST</b>		25. DATE RECD. BY LOCAL REG. <b>DEC 11 1959</b>		26. REGISTRAR'S SIGNATURE <b>Roan Smith M.D.</b> <b>A.C.M.</b>	

(Licensed Embalmer's Statement on Reverse Side)

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 \_\_\_\_\_ Student Embalmer No. \_\_\_\_\_

or by \_\_\_\_\_ working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Gustav W. Guita

Licensed Embalmer No. 432

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.