

**FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**60-002820**

**FILED VS JAN 13 1960**

Registration District No. 275 Primary Registration District No. 3053 Registrar's No. 4

STATE FILE NUMBER

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Helios</u> b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <u>Rolla</u> Length of stay in 1b <u>2 DAYS</u> c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Helios P. Mem. Hosp</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Crawford</u> c. CITY OR TOWN <u>Cuba</u> d. STREET ADDRESS (if outside, give location) <u>412 West James</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Thomas</u> Middle <u>—</u> Last <u>Gmielewski</u>			<b>4. DATE OF DEATH</b> Month <u>JANUARY</u> Day <u>3</u> Year <u>1960</u>				
<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. Married</b> <input type="checkbox"/> <b>Never Married</b> <input type="checkbox"/> <b>Widowed</b> <input checked="" type="checkbox"/> <b>Divorced</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>12/15/1885</u>	<b>9. AGE (last birthday)</b> <u>74</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>18</u> Hours <u>—</u> Min. <u>—</u>		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>laborer</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Factory</u>	<b>11. BIRTHPLACE</b> (City and state or country) <u>Poland</u>	<b>12. CITIZENSHIP AT DEATH</b> <u>Polish</u>			
<b>13a. FATHER'S NAME</b> <u>UNKNOWN</u>		<b>13b. MOTHER'S MAIDEN NAME</b> <u>UNKNOWN</u>		<b>14. NAME OF HUSBAND OR WIFE</b> <u>Mary Ann TRACY (Dec'd)</u>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> <u>333-03-1328</u>	<b>17. INFORMANT</b> <u>Julia Anderson, Cuba, Mo.</u>				
<b>18. CAUSE OF DEATH</b> (Enter only one cause by line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypostatic Pneumonia</u> DUE TO (b) <u>Metastatic Infiltration</u> DUE TO (c) <u>Cancer Etiology Not Known</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH <u>27 days</u> <u>4 months</u> <u>months to year</u>		
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			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)					
<b>20c. TIME OF INJURY</b> Hour <u>—</u> Month, Day, Year <u>—</u>							
<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> <b>NOT WHILE AT WORK</b> <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>20f. CITY, TOWN, OR LOCATION</b> COUNTY STATE			
<b>21. I attended the deceased from</b> <u>Aug 59</u> to <u>—</u> and last saw her/him alive on <u>2 Jan 60</u> Death occurred at <u>12:30 pm</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
<b>22a. SIGNATURE</b> (Degree or title) <u>Gordon W. Biffel MD</u>			<b>22b. ADDRESS</b> <u>Bourbon Mo.</u>		<b>22c. DATE SIGNED</b> <u>6 Jan 60</u>		
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>	<b>23b. DATE</b> <u>JAN. 7, 1960</u>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>CALVARY CEMETERY</u>		<b>23d. LOCATION (City, town, or county)</b> <u>St. Louis Mo.</u>			
<b>24. FUNERAL DIRECTOR</b> ADDRESS <u>—, Cuba, Mo.</u>		<b>25. DATE RECD. BY LOCAL REG.</b> <u>Jan. 6, 1960</u>	<b>26. REGISTRAR'S SIGNATURE</b> <u>Nadine L. Stoll</u>				

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

JAN 13 1900

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 Paul E. Ne

Licensed Embalmer No. 449

P. O. Address Rolla,

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