IRI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

-60-008234
STATE FILE NUMBER

FILED VS MAR 7 1960 Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Louis
Length of stay in 1b
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: 1529a Hogan Street.
Inside Limits: Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri
b. COUNTY
c. CITY OR TOWN: St. Louis
Inside Limits: Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location): 1529a Hogan St.
Reside on Farm: Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First FRANK Middle GALCZYNSKI Last
4. DATE OF DEATH: Month Feb. Day 20th, Year 1960

5. SEX: Male
6. COLOR OR RACE: White
7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 2/12/1893
9. AGE (last birthday): 67
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)
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and state or country): St. Louis, Mo.
12. CITIZEN OF WHAT COUNTRY: U.S.A.

13a. FATHER'S NAME: Paul Galczynski
13b. MOTHER'S MAIDEN NAME: Pauline Dombrowski
14. NAME OF HUSBAND OR WIFE: Rose Galczynski

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes (If yes, give war or dates of service): W. W. I
16. SOCIAL SECURITY NO.: 493-01-5561
17. INFORMANT: Mrs. Rose Galczynski Address: 1529a Hogan

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)	Coronary occlusion acute	1 hr.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)	Arteriosclerotic C.V. Heart Disease	8 yrs.
DUE TO (c)	Portal cirrhosis esophageal varices	8 yrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): 581.0

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
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 10/21/52, to 2/20/60 and last saw her/him alive on 2/20/60
Death occurred at 1:PM. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): [illegible] M.D.
22b. ADDRESS: 1901 Madison
22c. DATE SIGNED: 2/22/60

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 2/23/60
23c. NAME OF CEMETERY OR CREMATORY: National Cemetery
23d. LOCATION (City, town, or county) (State): Jefferson Bks., Mo.

24. FUNERAL DIRECTOR: CENTRAL UND. CO. ADDRESS: 1841 Cass Ave.
25. DATE REC'D BY LOCAL REG.: FEB 22 1960
26. REGISTRAR'S SIGNATURE: Earl Smith, M.D. m.g.

(Licensed Embalmer's Statement on Reverse Side)

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_____ Signed_____

Signature of Student Embalmer

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 co
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.