

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS MAY 13 1960

-60-016594

STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's **2 4352**

1. PLACE OF DEATH a. COUNTY _____		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</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>72 YRS</b>	c. CITY OR TOWN <b>ST. LOUIS</b>
c. FULL NAME OF HOSPITAL OR INSTITUTION <b>St. Louis City Hosp. #1</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>4313A. NO. FLORISSANT - AV.</b>
3. NAME OF DECEASED (Type or print) <b>Frank - ANDREW - Bedzmirowski</b>		4. DATE OF DEATH Month <b>April</b> Day <b>21</b> Year <b>1960</b>	

5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>7-13-1878</b>	9. AGE (last birthday) <b>81 YRS</b>	10. IF UNDER 1 YEAR Months _____ Days _____	11. IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PAINTER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>REFRIGERATION-IND.</b>		11. BIRTHPLACE (City and state or country) <b>GERMANY</b>		12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>
13a. FATHER'S NAME <b>JOHN-BEDZMIROWSKI</b>		13b. MOTHER'S MAIDEN NAME <b>JOSEPHINE-MIODUNSKI</b>		14. NAME OF HUSBAND OR WIFE <b>JULIA-BEDZMIROWSKI (DECD.)</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 <b>VINCENT-BEDZMIROWSKI = FLORISSANT - AV.</b>	Address <b>4313 A. NO.</b>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Vascular thrombosis</b>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>332 x</b>	

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 checked="" type="checkbox"/> N- <input type="checkbox"/> Unknown	
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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.)	
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 <b>ST. LOUIS</b>	COUNTY _____ STATE _____
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21. I attended the deceased from **4-12-60** to **4-21-60** and last saw him alive on **4-21-60**  
Death occurred at **1:05** **a**m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <b>William Donald Richardson M.D.</b>	22b. ADDRESS <b>1515 Lafayette Ave.</b>	22c. DATE SIGNED <b>4-21-60</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>4-25-1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>CALVARY-CEMETERY</b>	23d. LOCATION (City, town, or county) (State) <b>ST. LOUIS MO.</b>
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24. FUNERAL DIRECTOR <b>Brookland Und. Co. 1827-HOGAN-ST.</b>	25. DATE RECD. BY LOCAL REG. <b>APR 22 1960</b>	26. REGISTRAR'S SIGNATURE <b>Earl Smith, M.D.</b>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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