

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-020937

FILED VS JUN 6 1960

318

1003

5410

STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 5410

1. PLACE OF DEATH a. COUNTY <u>MISSOURI</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> , b. COUNTY <u>MISSOURI</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS</u>		Length of stay in 1b <u>55 YRS.</u>		c. CITY OR TOWN <u>ST. LOUIS</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ENROUTE: CITY-HOSPITAL#1</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>1452-MULLAMPHY-ST.</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ANTHONY</u> Middle <u>FRONCKIEWICZ</u> Last <u>FRONCKIEWICZ</u>			4. DATE OF DEATH Month <u>MAY</u> - Day <u>23</u> - Year <u>1960</u>				
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>9-28-1890</u>	9. AGE (last birthday) <u>69 YRS.</u>	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED: SHOE-WORKER</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>SAMUELS-SHOE-CO.</u>	11. BIRTHPLACE (City and state or country) <u>POLAND</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>STANLEY-FRONCKIEWICZ</u>			13b. MOTHER'S MAIDEN NAME <u>ALEXANDRIA-CZWIKLOWSKI</u>		14. NAME OF HUSBAND OR WIFE <u>ANNA-FRONCKIEWICZ</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u> <u>NONE</u>			16. SOCIAL SECURITY NO. <u>489-07-6429A.</u>	17. INFORMANT <u>ANNA-FRONCKIEWICZ</u> Address <u>1452-MULLAMPHY-ST.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thromboses</u>						INTERVAL BETWEEN ONSET AND DEATH <u>acute</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Bronchial asthma</u>						<u>15 YRS</u>	
DUE TO (c) <u>Arterio Sclerosis 420.1</u>						<u>15 YRS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>HYPERTENSION</u>						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.)			
20c. TIME OF INJURY Hour <u>  </u> a.m. <u>  </u> p.m.	Month, Day, Year <u>  </u> <u>  </u> <u>  </u>						
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 <u>May 24, 1960</u> to <u>May 21, 1960</u> and last saw <u>him</u> alive on <u>May 21, 1960</u> Death occurred at <u>5:45 A.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>May J. Galdenson, M.D.</u> (degree or title)			22b. ADDRESS <u>508 N. Grand</u>			22c. DATE SIGNED <u>5-24-60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>MAY-27-1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>CALVARY-CEMETERY</u>		23d. LOCATION (City, town, or county) <u>ST. LOUIS</u>		STATE <u>MO.</u>	
24. FUNERAL DIRECTOR <u>Brockland Und. G. 1827-HOGAN-ST.</u> ADDRESS			25. DATE RECD. BY LOCAL REG. <u>MAY 24 1960</u>		26. REGISTRAR'S SIGNATURE <u>Lead Smith, M.D.</u>		

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 James Beribley  
Licensed Embalmer No. 365  
P. O. Address St Louis

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