

FILED VS. SEP 21 1960

STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 9005

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|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY                                                                                                                                                                                                               |                                        |                                                                                                                                                             |                                                                           | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Missouri</u> b. COUNTY |                                                                               |                                                                                                                                                                      |                                                                                       |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <u>St. Louis</u>                                                                                                                                                        |                                        | Length of stay in 1b                                                                                                                                        |                                                                           | c. CITY OR TOWN <u>St. Louis</u>                                                                                            |                                                                               | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                                                                                 |                                                                                       |
| c. FULL NAME OF (IF NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <u>4439a Athlone Avenue</u>                                                                                                                                   |                                        |                                                                                                                                                             | Inside Limits<br>Yes <input type="checkbox"/> No <input type="checkbox"/> |                                                                                                                             | d. STREET ADDRESS (If outside, give location)<br><u>4439a Athlone Avenue.</u> |                                                                                                                                                                      | Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><u>PETER (Gotch Gatch) GACIOCH</u>                                                                                                                                               |                                        |                                                                                                                                                             |                                                                           | 4. DATE OF DEATH<br>Month Day Year<br><u>Sept. 11, 1960</u>                                                                 |                                                                               |                                                                                                                                                                      |                                                                                       |
| 5. SEX<br><u>Male</u>                                                                                                                                                                                                                        | 6. COLOR OR RACE<br><u>White</u>       | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/> |                                                                           | 8. DATE OF BIRTH<br><u>9/18/1887</u>                                                                                        | 9. AGE (last birthday)<br><u>72</u>                                           | IF UNDER 1 YEAR<br>Months Days Hours Min.                                                                                                                            | IF UNDER 24 HR                                                                        |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Retired</u>                                                                                                                                |                                        |                                                                                                                                                             | 10b. KIND OF BUSINESS OR INDUSTRY<br>* * * * *                            |                                                                                                                             | 11. BIRTHPLACE (City and state or country)<br><u>Poland</u>                   | 12. CITIZEN OF WHAT COUNTRY<br><u>U.S.A.</u>                                                                                                                         |                                                                                       |
| 13a. FATHER'S NAME<br><u>Peter Gacioch</u>                                                                                                                                                                                                   |                                        |                                                                                                                                                             | 13b. MOTHER'S MAIDEN NAME<br><u>Maryann Wilga</u>                         |                                                                                                                             | 14. NAME OF HUSBAND OR WIFE<br><u>None</u>                                    |                                                                                                                                                                      |                                                                                       |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) <u>no</u>                                                                                                                                                               |                                        | 16. SOCIAL SECURITY NO.<br>(If yes, give war or dates of service) <u>493-20-6564</u>                                                                        |                                                                           | 17. INFORMANT Address<br><u>Mrs. Helen Healey 4439a Athlone Av</u>                                                          |                                                                               |                                                                                                                                                                      |                                                                                       |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Lobar Pneumonia</u>                                                                                       |                                        |                                                                                                                                                             |                                                                           |                                                                                                                             |                                                                               |                                                                                                                                                                      | INTERVAL BETWEEN ONSET AND DEATH                                                      |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.                                                                                                                                                   |                                        |                                                                                                                                                             | DUE TO (b)                                                                |                                                                                                                             | DUE TO (c)                                                                    |                                                                                                                                                                      | <u>490x</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.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |                                                                                       |
| 19. WAS AUTOPSY PERFORMED?<br>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<br>Hour a.m. p.m.<br>Month, Day, Year                                                                                                                                                                                    |                                        |                                                                                                                                                             |                                                                           |                                                                                                                             |                                                                               |                                                                                                                                                                      |                                                                                       |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/><br>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>Aug 18 60</u> to <u>Sept 11</u> and last saw him alive on <u>Sept 11 60</u><br>Death occurred at <u>Sept 11 5 p</u> m on the date stated above, and to the best of my knowledge, from the causes stated. |                                        |                                                                                                                                                             |                                                                           |                                                                                                                             |                                                                               |                                                                                                                                                                      |                                                                                       |
| 22a. SIGNATURE (Degree or title)<br><u>J J Vignier M.D.</u>                                                                                                                                                                                  |                                        |                                                                                                                                                             |                                                                           | 22b. ADDRESS<br><u>3511 University</u>                                                                                      |                                                                               | 22c. DATE SIGNED<br><u>9/12/60</u>                                                                                                                                   |                                                                                       |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>                                                                                                                                                                                   | 23b. DATE<br><u>9/14/60</u>            | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Calvary Cemetery</u>                                                                                               |                                                                           | 23d. LOCATION (City, town, or county)<br><u>St. Louis, Missouri</u>                                                         |                                                                               | 23e. STATE<br><u>Missouri</u>                                                                                                                                        |                                                                                       |
| 24. FUNERAL DIRECTOR ADDRESS<br><u>John Stigar &amp; Son 5541 KIVERVIEW BLVD</u>                                                                                                                                                             |                                        |                                                                                                                                                             |                                                                           | 25. DATE RECD. BY LOCAL REG.<br><u>SEP 12 1960</u>                                                                          |                                                                               | 26. REGISTRAR'S SIGNATURE<br><u>Loard 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 \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_ or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_ working under my personal supervision.

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

Signed *W. Riste*

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 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.