

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-040461

FILED VS/OCT 24 1960

INDEXED

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 2889 STATE FILE NUMBER

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
a. COUNTY <u>St. Louis</u>		a. STATE <u>Mo.</u>		b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Clayton</u>		Length of stay in lb <u>D.O.A.</u>		c. CITY OR TOWN <u>St. Ann</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Louis Co., Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>3241 Airway Ave.</u>	
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>					

3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH			
First <u>Paul</u> Middle <u>Bialik</u> Last <u>Bialik</u>			Month <u>10</u> Day <u>3</u> Year <u>'60.</u>			

5. SEX <u>M</u>	6. COLOR OR RACE <u>W</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>2-11-08</u>	9. AGE (last birthday) <u>52</u>	IF UNDER 1 YEAR	IF UNDER 24 HR
				Months		Days
				Hours		Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Junk Dealer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Self</u>	11. BIRTHPLACE (City and state or country) <u>Pinelawn Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
--	---	--	---

13a. FATHER'S NAME <u>Paul Bialik</u>	13b. MOTHER'S MAIDEN NAME <u>Margaret Duffy</u>	14. NAME OF HUSBAND OR WIFE <u>Mildred Bialik</u>
---------------------------------------	---	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes 17-19-2</u>	16. SOCIAL SECURITY NO. <u>199-01-5811</u>	17. INFORMANT <u>Mildred Bialik 3241 Airway Mo</u>	Address <u>St Ann</u>
---	--	--	-----------------------

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) <u>Unknown Natural Causes</u>		
DUE TO (b) _____		
DUE TO (c) _____		
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"/> N <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 _____ 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 _____ COUNTY _____ STATE _____
---	--	--	---

21. I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_ and last saw her/him alive on \_\_\_\_\_.

Death occurred at 3:51A m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Joan C. Murphy MD Asst. Health Commissioner</u>	22b. ADDRESS <u>801 S. Brentwood, Clayton</u>	22c. DATE SIGNED _____
---	---	------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>10-5-160</u>	23c. NAME OF CEMETERY OR CREMATORY <u>National Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Jefferson Barracks Mo.</u>
---	---------------------------	---	---

24. FUNERAL DIRECTOR <u>Mittelberg</u> ADDRESS <u>Webster Groves Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>10-3-60</u>	26. REGISTRAR'S SIGNATURE <u>Joan C. Murphy 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 Stanley A. DePoe

Licensed Embalmer No. 419

P. O. Address S. L.

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.