URI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS OCT 24 1960

-60-040485

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 3010 STATE FILE NUMBER

1. PLACE OF DEATH
a. COUNTY: St. Louis
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: Clayton
Length of stay in 1b: 2 Days
c. FULL NAME OF HOSPITAL OR INSTITUTION: St. Louis County Hosp. Inside Limits: Yes # No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri b. COUNTY: St. Louis
c. CITY OR TOWN: Breckenridge Hills Inside Limits: Yes # No ☐
d. STREET ADDRESS (If outside, give location): 3342 Edmundson Rd. Reside on Farm: Yes ☐ No #

3. NAME OF DECEASED (Type or print): First: Joseph Middle: S. Last: Kozlowski

4. DATE OF DEATH: Month: October Day: 14 Year: 1960

5. SEX: Male

6. COLOR OR RACE: White

7. Married ☐ Never Married # Widowed ☐ Divorced ☐

8. DATE OF BIRTH: 11)9)1909

9. AGE (last birthday): 50

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): Auto Body Repair

10b. KIND OF BUSINESS OR INDUSTRY: Automobile

11. BIRTHPLACE (City and state or country): St. Louis County Mo.

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13a. FATHER'S NAME: Stanislaus Kozlowski

13b. MOTHER'S MAIDEN NAME: Anna Koch

14. NAME OF HUSBAND OR WIFE: Single

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: 494-03-2695

17. INFORMANT: Anna Kozlowski Address: 3342 Edmundson Rd.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pneumonitis & focal abscesses — INTERVAL BETWEEN ONSET AND DEATH: 2 wks
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Chronic passive congestion lung
DUE TO (c): Coronary artery heart disease
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): left ventricular aneurysm
PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

MEDICAL CERTIFICATION

19. WAS AUTOPSY PERFORMED? YES X 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 10-13-60 to 10-14-60 and last saw ~~her~~ him alive on 10-14-60. Death occurred at 11:40 P.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Albert L. Howe M.D.
22b. ADDRESS: 601 S. Brentwood, Clayton, Mo.
22c. DATE SIGNED: 10/15/60

BY AFFIDAVIT OF

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: 10)18)1960
23c. NAME OF CEMETERY OR CREMATORY: Calvary Cemetery
23d. LOCATION (City, town, or county) (State): St. Louis Mo.

24. FUNERAL DIRECTOR: Collier Mortuary, St. Ann, Mo.
ADDRESS

25. DATE RECD. BY LOCAL REG.: 10-17-60

26. REGISTRAR'S SIGNATURE: John C. Murphy M.D.

(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 Sheldon Collie

Signature of Student Embalmer

Licensed Embalmer No. 3382

P. O. Address St. Am

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