

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-048379

FILED VS JAN 9 1961 317

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 3759

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>ST LOUIS</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY _____			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>KOCH</u>		Length of stay in 1b <u>5 days</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>ROBT KOCH HOSP</u>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>8582 PART RIDGE</u>			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>PAUL</u> Middle <u>SZYDLOWSKI</u> Last <u>ST LOUIS</u>				4. DATE OF DEATH Month <u>Dec</u> Day <u>26</u> Year <u>1960</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>3-21-84</u>	9. AGE (last birthday) <u>78</u>	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) <u>UNK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>UNK</u>		11. BIRTHPLACE (City and state or country) <u>POLAND</u>		12. CITIZEN OF WHAT COUNTRY <u>USA 1902</u>	
13a. FATHER'S NAME <u>Andrew Szydowski</u>			13b. MOTHER'S MAIDEN NAME <u>Marg ?</u>		14. NAME OF HUSBAND OR WIFE <u>UNK</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>492-07-9909</u>		17. INFORMANT <u>Hospital Records - Robt Koch Hosp</u> Address _____			
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>Acute Intestinal Hemorrhage</u>						INTERVAL BETWEEN ONSET AND DEATH <u>? minutes</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Diverticulal ulcer</u>						?	
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"/> 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 _____ 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 <u>Dec 22/60</u> to <u>Dec 26/60</u> and last saw him alive on <u>Dec 26/60</u> Death occurred at <u>4 55 A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>Frank Collier MD</u> (Degree or title)			22b. ADDRESS <u>Robt Koch Hosp Koch MO</u>			22c. DATE SIGNED <u>12/26/60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>12-29-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Calvary</u>		23d. LOCATION (City, town, or county) <u>ST LOUIS MO</u>		23e. STATE <u>MO</u>	
24. FUNERAL DIRECTOR <u>St Louis Funeral H 2208 St Louis Ave</u>		ADDRESS		25. DATE RECD. BY LOCAL REG. <u>12-28-60</u>	26. REGISTRAR'S SIGNATURE <u>John W. Mungie MD</u>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

JAN 17 1961

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

John J. Haines

Licensed Embalmer No. 4108

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.