MISSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

-61-006977
STATE FILE NUMBER

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 1332

FILED VS FEB 20 1961

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Louis
Length of stay in 1b
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: Firmin Desloge Hospital
Inside Limits Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MO.
b. COUNTY
c. CITY OR TOWN: St. Louis
Inside Limits Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location): 1616 Carroll St.
Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First MARY Middle Last TUSTANOWSKY
4. DATE OF DEATH: Month Feb. Day 7 Year 1961
5. SEX: Female
6. COLOR OR RACE: Whitee
7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 2/7/94
9. AGE (last birthday): 67
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): Housewife
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and state or country): St. Louis, Mo.
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13a. FATHER'S NAME: Samuel Kostizak
13b. MOTHER'S MAIDEN NAME: Antonia Kostizak
14. NAME OF HUSBAND OR WIFE: Walter Tustanowsky
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Marie Tustanowsky Address: 1616 Carroll St.

MEDICAL CERTIFICATION

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)	Congestive heart failure	30 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)	Atherosclerotic cardiovascular disease & anemia	1-2 yrs.
DUE TO (c)	Epidermoid carcinoma cervix uteri Stage III	1-2 yrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): Acute Pyelonephritis 171x

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☒ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☒ 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 Oct 1960, to Feb 1961 and last saw her/him alive on 2/6/61
Death occurred at 5:30 A.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: Paul John Ritter MD (Degree or title)
22b. ADDRESS: 1325 So. Grand
22c. DATE SIGNED: 2/8/61

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 2/10/61
23c. NAME OF CEMETERY OR CREMATORY: St. Peter & Paul Cem
23d. LOCATION (City, town, or county) (State): St. Louis, Mo.

24. FUNERAL DIRECTOR: CHULICK UND. CO. ADDRESS: 1722 S. Jefferson
25. DATE RECD. BY LOCAL REG.: FEB 9 1961
26. REGISTRAR'S SIGNATURE: Hoard Smith, M.D.

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO.	SHOULD READ	INSTEAD OF	DATE AMENDED
			3

BY AFFIDAVIT OF DOCUMENT

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____, Student Embalmer No._____ working under my personal supervision.

Student_____
Signature of Student Embalmer

Signed V E Morris

Licensed Embalmer No. 3360

P. O. Address St Louis, M

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.