

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

LED MAY 4 1961 AMENDED 318 Primary Registration District No. 1003 Registrar's No. 3996 -61-015230 STATE FILE NUMBER

| | | | | | | | |
|--|---------------------------|---|---|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis | | Length of stay in 1b | | c. CITY OR TOWN St. Louis | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Mo. Baptist Hospital | | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) 6555 Arsenal St. | | Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First Middle Last ARTHUR T. KOSHOWSKY | | | 4. DATE OF DEATH Month Day Year Apr. 25 1961 | | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 3-19-1886 | 9. AGE (last birthday) 75 | 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) Deputy Marshall-City | | 10b. KIND OF BUSINESS OR INDUSTRY Police Courts | | 11. BIRTHPLACE (City and state or country) St. Louis, Mo. | | 12. CITIZEN OF WHAT COUNTRY U.S.A. | |
| 13a. FATHER'S NAME John Koshowsky | | | 13b. MOTHER'S MAIDEN NAME Frances Chnersbich | | 14. NAME OF HUSBAND OR WIFE Catharine | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No None | | | 16. SOCIAL SECURITY NO. - | | 17. INFORMANT Address Catharine Koshowsky 6555 Arsenal St. | | |
| 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>Cancer of Right Kidney c</u> <u>metastases to Liver & Lung</u> 180x Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| 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>March</u> to <u>April 25th</u> and last saw him alive on <u>April 25th</u> . Death occurred at <u>10:15 A.</u> m on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | |
| 22a. SIGNATURE (Degree or title) <u>Breton C. Kell ned</u> | | | | 22b. ADDRESS <u>3902 Lafayette</u> | | 22c. DATE SIGNED <u>4/26/61</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE Apr. 28, 1961 | | 23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery | | 23d. LOCATION (City, town, or county) St. Louis, Mo. | |
| 24. FUNERAL DIRECTOR ADDRESS Kriegshauser 4228 S. Kingshighway | | | | 25. DATE RECD. BY LOCAL REG. APR 26 1961 | | 26. REGISTRAR'S SIGNATURE <u>Loan Smith. M.D.</u> | |

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

STATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

SHOULD READ

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 me,
or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed Edwin A. Mc Dermott

Licensed Embalmer No. 3024

P. O. Address _____

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.