

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-015940  
STATE FILE NUMBER

AMENDED *J* FILED APR 27 1961 Registration District No. *317* Primary Registration District No. *500* Registrar's No. *1028*

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

1. PLACE OF DEATH a. COUNTY <b>Saint Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>Normandy</b>		Length of stay in 1b <b>10 days</b>	c. CITY OR TOWN <b>Saint Louis</b>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Normandy Osteopathic Hosp.</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>5923 Thekla</b>
3. NAME OF DECEASED (Type or print) First <b>Julia</b> Middle Last <b>Krolik</b>		4. DATE OF DEATH Month <b>April</b> Day <b>13</b> Year <b>1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>1-4-1888</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	9. AGE (last birthday) <b>73</b>
11a. BIRTHPLACE (City and state or country) <b>Radom, Illinois</b>		12. CITIZEN OF WHAT COUNTRY <b>U S A</b>	
13a. FATHER'S NAME <b>John Ciesinski</b>		13b. MOTHER'S MAIDEN NAME <b>Julia (unknown)</b>	14. NAME OF HUSBAND OR WIFE <b>Joseph Krolik</b>
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. *****	17. INFORMANT Address <b>Mrs. Delphine Gundrich-5923a Thekla</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory Paralysis</b> DUE TO (b) <b>Anoxia</b> DUE TO (c) <b>Pleural Effusion</b>			INTERVAL BETWEEN ONSET AND DEATH <b>Sec</b> <b>min</b> <b>WKS.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Hepato-megaly - Splenomegaly - Secondary Anemia</b>			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" 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.) <b>003.1</b>			
20c. TIME OF INJURY Hour a.m. p.m.		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 <b>4/13/61</b> to <b>4-13-61</b> and last saw her <sup>him</sup> alive on <b>4/13/61</b> Death occurred at <b>10:26 a.m.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>William D. McLawrence</b>		22b. ADDRESS <b>7011 Concordale Clayton St</b>	22c. DATE SIGNED <b>4-13-61</b>
23a. BURIAL, CREMATION, or other disposition <b>Funeral</b>	23b. DATE <b>4/17/1961</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>St. Louis Mo.</b>
24. FUNERAL DIRECTOR ADDRESS <b>JOHN STYGAR &amp; SON - 5541 RIVERVIEW BLVD.</b>		25. DATE REC'D. BY LOCAL REG. <b>4-14-61</b>	REGISTRAR'S SIGNATURE <b>J. G. Murphy M.D.</b>

**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 \_\_\_\_\_

Licensed Embalmer No. \_\_\_\_\_

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.