

SOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-61-046072

AMENDED

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **11540** STATE FILE NUMBER

FILED DEC 18 1961

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 3452 GRACE AVE			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 3452 GRACE AVE		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First MARY Middle BERNACKI Last				4. DATE OF DEATH Month DEC Day 9 Year 1961			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH MAY 8 1893	9. AGE (last birthday) 68	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WORK		10b. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (City and state or country) ILLINIOS		12. CITIZEN OF WHAT COUNTRY U-S-A	
13a. FATHER'S NAME JOHN BARYLSKI			13b. MOTHER'S MAIDEN NAME UNKNOWN		14. NAME OF HUSBAND OR WIFE STEVE BERNACKI		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT Address HELEN LANASA 3452 GRACE AVE			
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) Cancer of the esophagus & multiple Metastasis to the liver						4 MONTH	
DUE TO (b) liver							
DUE TO (c) 150x							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Coronary Heart disease						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.)			
20c. TIME OF INJURY Hour <input type="checkbox"/> a.m. <input type="checkbox"/> 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 6-24-55 to 12-9-61 and last saw her alive on 12-8-61 Death occurred at 9:00 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE Ernest Younger (Degree or title)				22b. ADDRESS NO. 3624 Russell		22c. DATE SIGNED 12-11-61	
23a. BURIAL, CREMATION, OR REMOVAL (Specify) BURIAL		23b. DATE DEC 12 1961		23c. NAME OF CEMETERY OR CREMATORY CALVARY CEMETERY		23d. LOCATION (City, town, or county) (State) ST. LOUIS MO.	
24. FUNERAL DIRECTOR Thomas Kutia 2906 Gravois ADDRESS				25. DATE RECD. BY LOCAL REG. DEC 11 1961		26. REGISTRAR'S SIGNATURE Loed Smith, M.D.	

MAIL ADDRESS

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

THEY WHO SHOULD READ

April 4, 1941

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 E. Eleuthero

Licensed Embalmer No. 3403
P. O. Address 2906 grova

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.