

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-008111
STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **1649**

DO NOT WRITE ON THIS STUB

AMENDED

FILED FEB 16 1962

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| VS 300 | AMENDMENTS ON THIS RECORD ARE AS FOLLOWS | INSTEAD OF | DOCUMENT |
| Rev. 4/59 | | | |
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| USE BLACK INK OR TYPEWRITER RIBBON | ITEM NO. | | |

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|--|---|---|---|
| 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 (18) | | c. CITY OR TOWN St. Louis (18) | |
| Length of stay in 1b 2 wks | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Lutheran Hospital | | d. STREET ADDRESS (If outside, give location) 3147 Osage St. | |
| Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) APOLONIA (Pauline) GOYDA | | | 4. DATE OF DEATH Month Feb. Day 7, Year 1962 |
| 5. SEX F | 6. COLOR OR RACE W | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 5/15/84 |
| 9. AGE (last birthday) 77 | | 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) None | | 10b. KIND OF BUSINESS OR INDUSTRY At Home | 11. BIRTHPLACE (City and state or country) Europe |
| 12. CITIZEN OF WHAT COUNTRY USA | | 13a. FATHER'S NAME Michael Adzima | |
| 13b. MOTHER'S MAIDEN NAME Barbara Skripko | | 14. NAME OF HUSBAND OR WIFE Deceased (Michael) | |
| 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 Walter Goyda | | Address 3147 Osage St. (18) | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL VASCULAR ACCIDENT | | | INTERVAL BETWEEN ONSET AND DEATH 2 wks |
| DUE TO (b) ARTERIOSCLEROSIS | | | |
| Conditions, if any, which gave rise to above cause (c), stating the underlying cause last. PARALYSIS AGITANS 331X | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) ARTERIOSCLEROTIC 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 Month, Day, Year 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 1957 to Present and last saw her alive on 2-6-62 Death occurred at 4 AM m on the date stated above, and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE <i>Leo J. Mallo</i> (Degree or title) MD | | 22b. ADDRESS 2900 Telegraph (25) | |
| 22c. DATE SIGNED 2-8-62 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal | 23b. DATE 2/9/62 | 23c. NAME OF CEMETERY OR CREMATORY Resurrection Cemetery | |
| 23d. LOCATION (City, town, or county) (State) St. Louis County Mo. | | | |
| 24. FUNERAL DIRECTOR Fendler Und. Co. 7420 Michigan (11) | | 25. DATE RECD. BY LOCAL REG. FEB 8 1962 | |
| 26. REGISTRAR'S SIGNATURE <i>Earl Smith, M.D.</i> | | | |

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 W. G. Peterson

Licensed Embalmer No. 3767

P. O. Address 7420 Michigan

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.