

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-008584

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. **318**

318

Primary Registration District No. **1003**

1003

Registrar's No. **1660**

1660

FILED FEB 16 1962

VS 300  
Rev. 4/59

1

2 **223**

3

4 **1**

5 **1**

6

7 **2**

8 **2**

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10

11

12 **90-0**

13

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY		b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS</b>		Length of stay in 1b		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MO.</b> b. COUNTY		c. CITY OR TOWN <b>ST. LOUIS</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>2242 SHENANDOAH</b>				Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>2242 SHENANDOAH</b>				Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>SOPHIE</b> Middle <b>PIETRZAK</b> Last						4. DATE OF DEATH Month <b>FEB</b> Day <b>6</b> Year <b>1962</b>					
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>JUNE 19 1893</b>		9. AGE (last birthday) <b>68</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (City and state or country) <b>POLAND</b>		12. CITIZEN OF WHAT COUNTRY <b>U-S-A</b>	
13a. FATHER'S NAME <b>ANTHONY MURASKA</b>				13b. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>				14. NAME OF HUSBAND OR WIFE <b>HENRY PIETRZAK</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>				16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT Address <b>EDITH PIETRZAK 2242 SHENANDOAH</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>arteriosclerotic heart disease</b>										INTERVAL BETWEEN ONSET AND DEATH <b>7 MO.</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Generalized arteriosclerosis</b>											
DUE TO (c) <b>420.0</b>											
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 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 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>4-23-56</b> to <b>2-6-62</b> and last saw her/him alive on <b>2-6-62</b> Death occurred at <b>2 P.</b> on the date stated above, and to the best of my knowledge, from the causes stated.											
22a. SIGNATURE (Degree or title) <b>Paul L. Sarcobak MD</b>						22b. ADDRESS <b>5208 CHIPPEWA ST. ST. LOUIS MO.</b>			22c. DATE SIGNED <b>2-7-62</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>		23b. DATE <b>FEB 9 1962</b>		23c. NAME OF CEMETERY OR CREMATORY <b>RESURRECTION CEM.</b>			23d. LOCATION (City, town, or county) (State) <b>ST. LOUIS CO. MO.</b>				
24. FUNERAL DIRECTOR <b>Thomas Kutis 2906 Gravois</b>				25. DATE RECD. BY LOCAL REG. <b>FEB 8 1962</b>		26. REGISTRAR'S SIGNATURE <b>Earl Smith, M.D.</b>					

St. Paul  
5203 Chippewa  
971-2454

**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 Eleanthorice

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

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.