

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-021570

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 547 Registrar's No. 1504

DO NOT WRITE ON THIS STUB

AMENDED

FILED JUN 7 1962

1. PLACE OF DEATH a. COUNTY St. Louis		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 Richmond Hts.		c. CITY OR TOWN St. Louis	
Length of stay in 1b 5 Weeks		Inside Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Mary's Hospital		d. STREET ADDRESS (If outside, give location) 5936 Arenades Dr.	
Yes <input type="checkbox"/> No <input type="checkbox"/>		Reside on Farm <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ANNA Middle M. Last WILUCKI			4. DATE OF DEATH Month May Day 18 Year 1962
5. SEX Female	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 7-15-1888
9. AGE (last birthday) 73		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) Housework		10b. KIND OF BUSINESS OR INDUSTRY At Home	11. BIRTHPLACE (City and state or country) St. Louis, Mo.
12. CITIZEN OF WHAT COUNTRY U.S.A.		13a. FATHER'S NAME Joseph Knoll	
13b. MOTHER'S MAIDEN NAME Antonio Unknown		14. NAME OF HUSBAND OR WIFE Dr. Leo E. Wilucki	
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 Dr. Leo E. Wilucki 5936 Arenades Dr.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac decompensation			INTERVAL BETWEEN ONSET AND DEATH 2 wks
DUE TO (b) AS CVR disease			Uncertain
DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) None			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.) None	
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 Apr. 25, 1957 to May 18, 1962 and last saw her alive on May 17, 1962 Death occurred at 12:30 A. _____ m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) A.S. Oppenheimer M.D.		22b. ADDRESS 35 N. Central Ave, Clayton 5, Mo.	22c. DATE SIGNED May 18, 1962
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE May 21, 1962	23c. NAME OF CEMETERY OR CREMATORY Concordia Cemetery	23d. LOCATION (City, town, or county) St. Louis, Mo.
24. FUNERAL DIRECTOR Kriegshauser 4228 S. Kingshighway Blvd.		25. DATE RECD. BY LOCAL REG. 5-18-62	26. REGISTRAR'S SIGNATURE John B. Mumfry M.D.

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DATE AMENDED
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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
INSTEAD OF
DOCUMENT
MEDICAL CERTIFICATION
SHOULD READ
BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

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 R. W. Stover

Licensed Embalmer No. 4007

P. O. Address St. Louis, Mo

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.