

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-029218

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **6849**

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **6849**
 JUL 31 1962

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Mo.		Length of stay in 1b		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri COUNTY		c. CITY OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>									
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Louis City Hosp. #1				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 2305 N. Florissant				Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First ANTON Middle SZALKOWSKI Last			4. DATE OF DEATH Month 7 Day 10 Year 62			5. SEX Male		6. COLOR OR RACE White		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>		8. DATE OF BIRTH 6-13-1888		9. AGE (last birthday) 79		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) Carpenter						10b. KIND OF BUSINESS OR INDUSTRY						11. BIRTHPLACE (City and state or country) Poland			12. CITIZEN OF WHAT COUNTRY U. S. A.				
13a. FATHER'S NAME John Szalkowski						13b. MOTHER'S MAIDEN NAME Henrietta						14. NAME OF HUSBAND OR WIFE Mary Szalkowski							
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 Mary Szalkowski 4638 Pope Ave.							
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 Thrombosis												INTERVAL BETWEEN ONSET AND DEATH							
DUE TO (b) Cerebral Arteriosclerosis																			
DUE TO (c) 332X																			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Arteriolar Nephrosclerosis												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 checked="" type="checkbox"/> NO <input 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 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 7-5-62 to 7-10-62 and last saw her/him alive on 7-10-62 Death occurred at 3:05 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.																			
22a. SIGNATURE (Degree or title) David L. Beato M.D.						22b. ADDRESS 1515 Lafayette Avenue						22c. DATE SIGNED 7-10-62							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 7-12-62			23c. NAME OF CEMETERY OR CREMATORY Calvary			23d. LOCATION (City, town, or county) (State) St. Louis, Missouri										
24. FUNERAL DIRECTOR ADDRESS St. Louis Funeral Home						25. DATE RECD. BY LOCAL REG. JUL 11 1962			26. REGISTRAR'S SIGNATURE Earl Smith M.D.										

USE BLACK INK OR TYPEWRITER RIBBON

Beato

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 John J. Harris

Licensed Embalmer No. 4408

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.