

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-040388

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. **318**
FILED NOV 18 1962

Primary Registration District No. **1003**

Registrar's No. **10515**

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b 16yrs	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. Luke's Hospital			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 2915a N. 13th	
3. NAME OF DECEASED (Type or print) First John Middle KARPOWICZ Last			4. DATE OF DEATH Month November Day 1 Year 1962		
5. SEX Male	6. COLOR OR RACE Caucasian	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 3-20-95	9. AGE (last birthday) 67	IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chipper		10b. KIND OF BUSINESS OR INDUSTRY Steel Industry	11. BIRTHPLACE (City and state or country) Poland	12. CITIZEN OF WHAT COUNTRY U.S. Nat.	
13a. FATHER'S NAME Simon Karpowicz		13b. MOTHER'S MAIDEN NAME Mariane Kalinowski		14. NAME OF HUSBAND OR WIFE Frances Karpowicz	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of serv) NO			16. SOCIAL SECURITY NO.	17. INFORMANT Address Frances Karpowicz, 2915A N. 13th St.	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY:					INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION					6 HRS.
DUE TO (b) ARTERIOSCLEROTIC HEART DISEASE					6 YEARS
DUE TO (c) 420.0					
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 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 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 10/30/62 to 11/1/62 and last saw ^{her} him alive on 11/1/62 Death occurred at 4:30 P. m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) William A. Furlong, M.D.			22b. ADDRESS 3720 Washington		22c. DATE SIGNED 11/2/62
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Nov. 5, 1962	23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	23d. LOCATION (City, town, or county) St. Louis, Missouri		(State)
24. FUNERAL DIRECTOR Arthur J. Donnelly			3840 Lindell Blvd.	25. DATE RECD. BY LOCAL REG. NOV 2 1962	REGISTRAR'S SIGNATURE Roan Smith, M.D.

USE BLACK INK OR TYPEWRITER RIBBON

81

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,

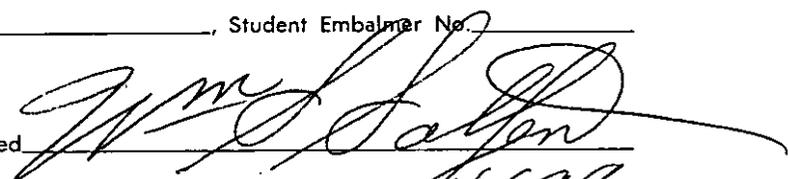
or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed _____



Licensed Embalmer No. _____

P. O. Address _____

4699
3840 Linder

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.