

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-048629

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 12520 STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED JAN 10 1968

VS 300 Rev. 4/59	DATE AMENDED
1	
2 <u>2239</u>	
3	
4 <u>0</u>	
5 <u>1</u>	
6	
7 <u>0</u>	
8 <u>1</u>	
9	
10	
11	
12 <u>63-0</u>	
13	
<u>63</u>	

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

USE BLACK INK OR TYPEWRITER RIBBON

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. Louis</u>		c. CITY OR TOWN <u>ST. Louis</u>	
Length of stay in 1b		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>INCARNATE WORD HOSP</u>		d. STREET ADDRESS (If outside, give location) <u>2134 NEBRASKA</u>	
Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>A.</u> Last <u>Nowak</u>			4. DATE OF DEATH Month <u>Dec</u> Day <u>26</u> Year <u>1962</u>
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT 20, 1916</u>
9. AGE (last birthday) <u>46</u>		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) <u>PAINTER</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Mo.</u>
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>			
13a. FATHER'S NAME <u>ALBERT NOWAK</u>		13b. MOTHER'S MAIDEN NAME <u>FRANCES CAPIK</u>	14. NAME OF HUSBAND OR WIFE <u>Helen Nowak</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, <u>yes</u> , or unknown) (If yes, give war or dates of service) <u>WW II</u>		16. SOCIAL SECURITY NO.	17. INFORMANT Address <u>Helen Nowak 2134 NEBRASKA</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u>			INTERVAL BETWEEN ONSET AND DEATH <u>14 days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			<u>4201</u>
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 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 <u>12-3-62</u> to <u>12-26-62</u> and last saw him alive on <u>12-26-62</u> Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>S. Dworkin M.D.</u>		22b. ADDRESS <u>1657 So Grand</u>	22c. DATE SIGNED <u>12-26-62</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>DEC 29, 1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>CALVARY OPM.</u>	23d. LOCATION (City, town, or county) (State) <u>ST. Louis Mo.</u>
24. FUNERAL DIRECTOR <u>Thomas Kulis</u> ADDRESS <u>2906 Gravois</u>	25. DATE RECD. BY LOCAL REG. <u>DEC 28 1962</u>	26. REGISTRAR'S SIGNATURE <u>Roan Smith, M.D.</u>	

Dr. Overman

1657 & Strand PR 62200

12-3 PM ~~FR~~ FR 1

Henry

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 *Carley Thompson Jr.*

Licensed Embalmer No. 4861

P. O. Address St. Louis 19 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.