

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

**63-022666**

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 1734

DO NOT WRITE ON THIS STUB

AMENDED

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Rev. 4/59

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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

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|  |   |   |   |   |  |  |  |
|--|---|---|---|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>St. Louis</u>  |   |   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Mo.</u> b. COUNTY <u>St. Louis</u> |  |  |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br><u>Clayton</u>  |   |   | Length of stay in 1b  |   | c. CITY OR TOWN <u>Floedel Hills</u>   |  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <u>St. Louis County Hospital</u>  |   |   |   | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  |  | d. STREET ADDRESS <u>7105 W. Florissant</u><br>(If outside, give location) |  |
| 3. NAME OF DECEASED<br>(Type or print) <u>RAYMOND C. (LUTOSKI) LUTOSTANSKI</u>   |   |   |   | First Middle Last   |  | 4. DATE OF DEATH<br><u>May 30 1963</u><br>Month Day Year                   |  |
| 5. SEX<br><u>Male</u>  | 6. COLOR OR RACE<br><u>White</u>  | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/> | 8. DATE OF BIRTH<br><u>8/16/1916</u>                          | 9. AGE (last birthday)<br><u>46</u>   | IF UNDER 1 YEAR<br>Months Days Hours Min.  |  | IF UNDER 24 HR<br>Hours Min.   |
| 10a. USUAL OCCUPATION (Give kind of work done or most of working life, even if retired)<br><u>Retired</u>  |   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Unemployed</u>        |   | 11. BIRTHPLACE (City and state or country)<br><u>St. Louis Mo.</u>   |  | 12. CITIZEN OF WHAT COUNTRY<br><u>U.S.A.</u>   |
| 13a. FATHER'S NAME<br><u>Boleslaw Lutostanski</u>  |   |   | 13b. MOTHER'S MAIDEN NAME<br><u>Anna Lemaneh</u>              |   |  | 14. NAME OF HUSBAND OR WIFE<br><u>None</u>                                 |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, No, or unknown) (If yes, give dates of service)<br><u>No</u>  |   |   | 16. SOCIAL SECURITY NO.<br>*****                              |   | 17. INFORMANT<br><u>Ben Lutostanski 7105 W. Florissant Ave</u><br>Address  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line)<br>PART I: DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Unknown natural causes</u>  |   |   |   |   |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>Unk</u>                                       |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.<br>DUE TO (b) _____<br>DUE TO (c) _____   |   |   |   |   |  |  |  |
| 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.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |  |  |
| 19. WAS AUTOPSY PERFORMED?<br>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<br>Hour _____ a.m. _____ p.m.<br>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 _____ to _____ and last saw her/him alive on _____<br>Death occurred at <u>6:43 A.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated. |   |   |   |   |  |  |  |
| 22a. SIGNATURE<br><u>Raymond Hair</u> (Degree or title)<br>Coroner, Clayton, Missouri  |   |   |   | 22b. ADDRESS  |  | 22c. DATE SIGNED<br><u>6/5/63</u>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Removal</u>  |   | 23b. DATE<br><u>6/1/63</u>  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Calvary Cemetery</u> |   | 23d. LOCATION (City, town, or county) (State)<br><u>St. Louis Mo.</u>  |  |  |
| 24. FUNERAL DIRECTOR<br><u>JOHN STYGAR &amp; SON - 5541 RIVERVIEW BLVD.</u> ADDRESS  |   |   |   | 25. DATE RECD. BY LOCAL REG.<br><u>5-31-63</u>  |  | 26. REGISTRAR'S SIGNATURE<br><u>John S. Murphy</u>                         |  |

St. Louis County Coroner

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 *J.M. Rister*

Licensed Embalmer No. 3980

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.

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