

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-030231

STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **7161**

DO NOT WRITE ON THIS STUB

AMENDED

FILED JUL 19 1963

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
INSTEAD OF

DOCUMENT

1. PLACE OF DEATH a. COUNTY		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 St. Louis, Mo.		Length of stay in 1b 4 yr 140 day	c. CITY OR TOWN St. Louis Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Louis Chronic		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 2450 So. Third St. Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Joseph Middle Last Lutrzykowski			4. DATE OF DEATH Month 7 Day 9 Year 1963			
5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 12-6-91	9. AGE (last birthday) 71	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		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 Frank		13b. MOTHER'S MAIDEN NAME Mary		14. NAME OF HUSBAND OR WIFE		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of)			16. SOCIAL SECURITY NO.		17. INFORMANT Address R. E. Perkowski 3314 Cherokee	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA, BILATERAL		4 days
Conditions, if any, which gave rise to above cause (e), stating the underlying cause last.	DUE TO (b) COMPENSATIVE CARDIAC FAILURE	3 WEEKS
	DUE TO (c) ARTERIOSCLEROTIC HEART DISEASE	5 YEARS

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) PARKINSONISM 420.0		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	
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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 **2-19-59** to **7-9-63** and last saw her/him alive on **7-9-1963**
Death occurred at **9:50 A.M.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>John J. Keeney M.D.</i>	(Degree or title)	22b. ADDRESS 5800 Arsenal Ave	22c. DATE SIGNED 7-10-63
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23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE July 13-1963	23c. NAME OF CEMETERY OR CREMATORY SS Peter & Paul	23d. LOCATION (City, town, or county) St. Louis
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24. FUNERAL DIRECTOR Thomas Kutas 2906 Gravois	25. DATE RECD. BY LOCAL REG. JUL 10 1963	26. REGISTRAR'S SIGNATURE <i>Paul Smith, M.D.</i>
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USE BLACK INK OR TYPEWRITER RIBBON

ITEM NO. SHOULD READ

BY AFFIDAVIT OF

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 *Corley Thompson*
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.