

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-037398

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **9149**

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED SEP 19 1963

VS 300
Rev. 4/59

1
2 *217*
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4 *1*
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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		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		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Louis University Hospital		d. STREET ADDRESS (If outside, give location) 3920 a Castleman	
3. NAME OF DECEASED (Type or print) First Theodora Middle Bukowsky Last Bukowsky		4. DATE OF DEATH Month 9 Day 5 Year 63	
5. SEX Female	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 9/5/63
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none	11. BIRTHPLACE (City and state or country) St. Louis, Mo.
13a. FATHER'S NAME Eugene Walter Bukowsky		13b. MOTHER'S MAIDEN NAME Naomi Marie Turck	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		17. INFORMANT Joan Bukowsky 3930 a Castleman	
18. CAUSE OF DEATH (Enter only one cause per time for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Immature Respiratory Function			INTERVAL BETWEEN ONSET AND DEATH 5:40-7:10 pm
DUE TO (b) _____ DUE TO (c) Prematurity (400 gms)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 773.5			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.	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 6:30 pm to 7:10 pm and last saw her alive on 9/5/63 Death occurred at 7:10 pm on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Physician or title) Thomas C. Helms MD.		22b. ADDRESS Cardinal Glennon Hosp.	22c. DATE SIGNED 9/5/63
23a. BURIAL, CREMATION, REMOVAL (Specify) 9-30-63	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY Anatomical Board	23d. LOCATION (City, town, or county) (State) St. Louis, Mo.
24. FUNERAL DIRECTOR ADDRESS MO. ANATOMICAL BOARD, 1402 S. GRAND		25. DATE RECD. BY LOCAL REG. SEP 12 1963	26. REGISTRAR'S SIGNATURE Joan Smith, M.D.

USE BLACK INK OR TYPEWRITER RIBBON

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 _____ Signed _____
Signature of Student Embalmer

Licensed Embalmer No. _____

P. O. Address _____

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.