

MISSOURI DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No.

30907

FILED OCT 1 1948

Registration District No.

318

Primary Registration District No.

100's

Registrar's No.

8275

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County \_\_\_\_\_  
(b) City or town St. Louis  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: St. Johns Hospital (D)  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 3 weeks  
(Specify whether  
In this community 43  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 0000  
(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. 1619 Helen St  
(If rural, give location)  
(e) Citizen of foreign country? NO (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Teofil Chrostowski

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex MALE 5. Color or race W  
6. (a) Single, widowed, married, divorced married  
(b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive 61 years  
7. Birth date of deceased Nov-13-1888  
(Month) (Day) (Year)

8. AGE: Years 66 Months 10 Days 7  
If less than one day hr. min.

9. Birthplace Poland  
(City, town, or county) (State or foreign country)

10. Usual occupation Retired

11. Industry or business \_\_\_\_\_

12. Name Miriam Chrostowski

13. Birthplace Poland  
(City, town, or county) (State or foreign country)

14. Maiden name Francis Siedlecker

15. Birthplace Poland  
(City, town, or county) (State or foreign country)

16. (a) Informant Teofil Chrostowski

(b) Address 1619 1/2 Helen St.

17. (a) Burial (b) Date thereof 9-23-48  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cem.

18. (a) Signature of funeral director J. F. Bradeck

(b) Address 2205 St. Louis Ave

19. (a) SEP 21 1948 (b) J. F. Bradeck  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 20  
year 1948 hour 4:37 minute 10 A. M.

21. I hereby certify that I attended the deceased from Aug 2, 1948, to Sept. 20, 1948  
and that I last saw him alive on Sept. 19, 1948  
and that death occurred on the date and hour stated above.

Immediate cause of death Hypostatic Pneumonia  
Carcinoma of Esophagus 2 1/2  
Duration 3 days

Due to \_\_\_\_\_  
Due to H/O  
Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_

Of autopsy Hypostatic Pneumonia  
Carcinoma of Esophagus

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature R. C. Welsh (M. D. or other) M.D.  
Address 4030 Chariton Date signed 9/21/48

PHYSICIAN

Underline the cause to which death should be charged statistically.



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**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.....

....., Registered Apprentice No.....  
working under my personal supervision.

Signed Robert M. Murray

Licensed Embalmer No. 3749

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 this body is not embalmed, fact should be so stated above.**