

FILED FEB 23 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **6786**
Registrar's No. **1116**

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. 1116	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St Louis		c. LENGTH OF STAY (in this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St Louis		d. STREET ADDRESS (If rural, give location) 149 St George Street	
d. FULL NAME OF HOSPITAL OR INSTITUTION: 149 St George Street				d. STREET ADDRESS (If rural, give location) 149 St George Street			
3. NAME OF DECEASED (Type or Print) a. (First) Walter b. (Middle) _____ c. (Last) Walewski			4. DATE OF DEATH (Month) (Day) (Year) Feb 3 1949				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced		8. DATE OF BIRTH May 1 1896	
9. AGE (In years last birthday) 52		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) Poland	
12. CITIZEN OF WHAT COUNTRY? U S A		13a. FATHER'S NAME John Walewski		13b. MOTHER'S MAIDEN NAME Mary Kovalski		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 service) _____		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME Mary Wojtowicz ADDRESS 149 St George St			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic myocarditis ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Alcoholism				INTERVAL BETWEEN ONSET AND DEATH 6 mo	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____			
22. I hereby certify that I attended the deceased from 1-25, 1949 , to 2-3, 1949 , that I last saw the deceased alive on 1-25, 1949 and that death occurred at _____ m., from the causes and on the date stated above.							
23a. SIGNATURE Oley J Jones (Degree or title) M.D.				23b. ADDRESS 3676 S. Broadway		23c. DATE SIGNED 2-4-49	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 2/4/49		24c. NAME OF CEMETERY OR CREMATORY Resurrection Cemetery		24d. LOCATION (City, town, or county) (State) St Louis	
DATE REC'D BY LOCAL REG. FEB 5		REGISTRAR'S SIGNATURE J. B. Lariter		25. FUNERAL DIRECTOR'S SIGNATURE Wm C Moydell Und ADDRESS 1926 Allen Av			

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

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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 me

Student Embalmer No.

working under my personal supervision.

Signed

Benny J. Duncan

Signed
Student Embalmer

Licensed Embalmer No. 2272

P. O. Address 1926 Allen Ave.

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.