

FILED APR 1 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 10538

#92669

318

1003

2493

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		Registrar's No. _____		
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo.</u> b. COUNTY <u>Wash</u>				
b. CITY (If outside corporate limits, write RURAL and give town or town _____ <u>St. Louis, Mo.</u>		c. LENGTH OF STAY (in this place) (township) _____		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN _____ <u>ST. Louis</u>		17 19		
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) _____ <u>St. Louis City Hospital #1.</u>				d. STREET ADDRESS (If rural, give location) _____ <u>2701 ELLIOT ST.</u>				
3. NAME OF DECEASED (Type or Print) a. (First) _____		b. (Middle) _____		c. (Last) _____		4. DATE OF DEATH (Month) (Day) (Year) <u>March 17th, 1949</u>		
5. SEX <u>M</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) _____ <u>WIDOWED</u>		8. DATE OF BIRTH <u>Feb. 15, 1875</u>		
9. AGE (In years last birthday) _____		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 18 HRS. Hours _____ Min. _____		9. AGE (In years last birthday) <u>74</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) _____ <u>HAULING</u>			10b. KIND OF BUSINESS OR INDUSTRY _____			11. BIRTHPLACE (State or foreign country) _____ <u>Poland</u>		
12. CITIZEN OF WHAT COUNTRY? _____ <u>Poland</u>			13a. FATHER'S NAME _____ <u>UNKNOWN</u>		13b. MOTHER'S MAIDEN NAME _____ <u>unknown</u>		14. NAME OF HUSBAND OR WIFE _____ <u>Pauline Dabrowski</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____ <u>No</u>		16. SOCIAL SECURITY NO. _____ <u>No</u>		17. INFORMANT'S SIGNATURE OR NAME _____ <u>MRS Katherine Nowawinski</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH		
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) _____ <u>central hemorrhage, cause undet.</u>		ANTECEDENT CAUSES (b) _____ <u>intertrochanteric fracture of femur</u>						
*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		DUE TO (c) _____ <u>arterio-sclerotic head disease</u>						
II. OTHER SIGNIFICANT CONDITIONS (Conditions contributing to the death but not related to the disease or condition causing death.) _____ <u>Psychosis - cerebral</u>		_____						
19a. DATE OF OPERATION _____ <u>3/10/49</u>		19b. MAJOR FINDINGS OF OPERATION _____ <u>arterio-sclerosis</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____ <u>Accident In hospital</u>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office, hotel, etc.) _____		21c. (CITY, TOWN OR TOWNSHIP) (COUNTY) (STATE) <u>St. Louis, MO MO</u>				
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____ <u>Dec 14, '48 8:00 PM</u>		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____ <u>Fall.</u>				
22. I hereby certify that I attended the deceased from <u>12/14/48</u> 19 <u>48</u> , to <u>3/17/49</u> , 19 <u>49</u> , that I last saw the deceased alive on <u>3/17/49</u> , 19 <u>49</u> , and that death occurred at <u>4:10 PM</u> , from the causes and on the date stated above.								
23a. SIGNATURE (Degree or title) _____ <u>Paul W. Caswell M.D.</u>				23b. ADDRESS _____ <u>1515 Lafayette Ave.,</u>		23c. DATE SIGNED _____ <u>3/18/49</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify) _____ <u>Burial</u>		24b. DATE _____ <u>3-21-49</u>		24c. NAME OF CEMETERY OR CREMATORY _____ <u>Calvary</u>		24d. LOCATION (City, town, or county) (State) _____ <u>St. Louis MO</u>		
DATE REC'D BY LOCAL REG. _____ <u>MAR 19 1949</u>		REGISTRAR'S SIGNATURE _____ <u>J. B. Lasater</u>		25. FUNERAL DIRECTOR'S SIGNATURE _____ <u>St. Louis Funeral Home</u>				

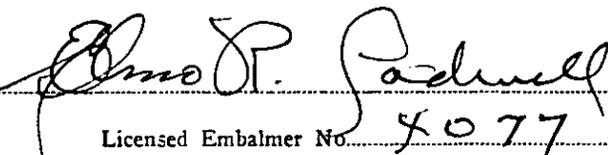
WRITE PLAINLY--USING UNFADING BLACK INK--MAKE A PERMANENT RECORD

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.

Signed..... .....
Licensed Embalmer No. 4077

Signed.....
Student Embalmer

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