

FILED OCT 7 1949

THE DIVISION OF HEALTH OF MISSOURI  
 STANDARD CERTIFICATE OF DEATH

32367

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1003

State File No. ....

8377

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 <b>Mo</b> b. COUNTY <b>St Louis</b>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St Louis Mo</b>		c. LENGTH OF STAY (In this place)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St Louis</b>			
d. FULL NAME OF HOSPITAL OR INSTITUTION: <b>1821 North 20th Str /</b>				d. STREET ADDRESS (If rural, give location) <b>20 - 1821 North 20th str.</b>			
3. NAME OF DECEASED (Type or Print) a. (First) <b>Bernice</b>		b. (Middle)		c. (Last) <b>Zyro</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>9 28 49</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Married</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widow</b>		8. DATE OF BIRTH <b>May 19/ 1870</b>	
9. AGE (In years last birthday) <b>79</b>		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Poland 4</b>		12. CITIZEN OF WHAT COUNTRY?	
13a. FATHER'S NAME <b>Julius Racharski</b>		13b. MOTHER'S MAIDEN NAME <b>Sophie OO</b>		14. NAME OF HUSBAND OR WIFE <b>Joseph Zyro</b>			
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 ADDRESS <b>Mrs Alice Koszykowska 1821 N20th</b>			
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Sensitivity</b>  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.				INTERVAL BETWEEN ONSET AND DEATH <b>3 yrs</b>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <b>no</b>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <b>162 St Louis Mo</b>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <b>79HX</b>			
22. I hereby certify that I attended the deceased from <b>1936</b> , to <b>Sept, 1949</b> that I last saw the deceased alive on <b>Sept, 1949</b> , and that death occurred at <b>3:30</b> m., from the causes and on the date stated above.							
23a. SIGNATURE <b>S. Hester M.D.</b> (Degree or title)				23b. ADDRESS <b>5600 S Compton</b>		23c. DATE SIGNED <b>9/29/49</b>	
24a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>Oct 1/49</b>		24c. NAME OF CEMETERY OR CREMATORY <b>St Peter's Cemetery</b>		24d. LOCATION (City, town, or county) (State) <b>St Louis County</b>	
DATE REC'D BY LOCAL REG. <b>SEP 29 1949</b>		REGISTRAR'S SIGNATURE <b>R. B. Basater</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Central Funeral Home 1841 Cass ave</b>			

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.

Student .....  
Student Embalmer

Signed *J. W. Binkley* .....

Licensed Embalmer No. *3653* .....

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.