

FILED DEC 1 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

38813

State File No.

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **9759**

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, write RURAL and give township) OR TOWN St. Louis		c. LENGTH OF STAY (in this place) 4 Days	
d. FULL NAME OF HOSPITAL OR INSTITUTION Alexian Bros. Hosp.		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis 2019	
		d. STREET ADDRESS (If rural, give location) 8509 Minnesota 0	

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH (Month) (Day) (Year)		
a. (First) Peter	b. (Middle) Maszko	c. (Last)	Nov. 14 1950		

5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Mch. 25 1891	9. AGE (In years last birthday) 59	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 24 HRS. Hours	IF UNDER 24 HRS. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Forman	10b. KIND OF BUSINESS OR INDUSTRY Portland Cem. Co.	11. BIRTHPLACE (State or foreign country) Ashley Ill.	12. CITIZEN OF WHAT COUNTRY?
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13a. FATHER'S NAME Michael Maszko	13b. MOTHER'S MAIDEN NAME Agatha Deering	14. NAME OF HUSBAND OR WIFE Celestine
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME Celestine Maszko	ADDRESS 8509 Minnesota
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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.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hyg Congestive heart failure		INTERVAL BETWEEN ONSET AND DEATH 2-3 yrs.
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hyg hypertensive heart disease		
	DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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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)
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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 443 X
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22. I hereby certify that I attended the deceased from **11-10-50**, to **11-14**, 19**50**, that I last saw the deceased alive on **11-14-50**, and that death occurred at **20** m., from the causes and on the date stated above.

23a. SIGNATURE [Signature]	(Degree or title)	23b. ADDRESS 11 Hampton Village	23c. DATE SIGNED 10/16/50
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Nov. 18 1950	24c. NAME OF CEMETERY OR CREMATORY Mt. Hope	24d. LOCATION (City, town, or county) (State) St. Louis Co. Mo.
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DATE REC'D BY LOCAL REG. NOV 17 1950	REGISTRAR'S SIGNATURE J. B. Pascoe	25. FUNERAL DIRECTOR'S SIGNATURE JOS. P. FENDLER, JR.	ADDRESS FUNERAL HOME MICHIGAN
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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 _____

working under my personal supervision.

Signed.....
Student Embalmer

Signed

Clarence Rochon

Student Embalmer No.....

Licensed Embalmer No. 3093

P. O. Address 7128 Michigan

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.