S. No. 300
v. 10.48

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

FILED NOV 30 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 39973

BIRTH NO. 82359-51 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 9647

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Louis
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Firmin Desloge Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission).
a. STATE: Mo.
b. COUNTY: St Louis
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): 4260
d. STREET ADDRESS (If rural, give location): 3610 Hoffmeister, 23

3. NAME OF DECEASED (Type or Print)
a. (First): Gregory
b. (Middle): Carl
c. (Last): Zielinski

4. DATE OF DEATH (Month) 10 (Day) 31 (Year) 51

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): D
8. DATE OF BIRTH: 10-31-51
9. AGE (In years last birthday): IF UNDER 1 YEAR Months Days; IF UNDER 24 HRS. Hours Min. 14
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): St. Louis, Mo.
12. CITIZEN OF WHAT COUNTRY?
13a. FATHER'S NAME: William Vincent Zielinski
13b. MOTHER'S MAIDEN NAME: Gertrude E. Dames
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: Gertrude E. Zielinski
ADDRESS: 3610 Hoffmeister

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, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Foetal Anoxia.
INTERVAL BETWEEN ONSET AND DEATH: 14 min.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Maternal. Low Reserve Kidney.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Enlarged Spleen: —

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

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) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR? 759.3

22. I hereby certify that I attended the deceased from _____, 19__, to 10-31, 1951, that I last saw the deceased alive on _____, 19__, and that death occurred at 1 P. m., from the causes and on the date stated above.

23a. SIGNATURE: R W Stevens (Degree or title) M.D.
23b. ADDRESS: 638 N. Grand.
23c. DATE SIGNED: 10/31/51

24a. BURIAL, CREMATION, REMOVAL (Specify): burial
24b. DATE: Nov. 3, 51
24c. NAME OF CEMETERY OR CREMATORY: Mt. Olive Cemetery
24d. LOCATION (City, town, or county) (State): Lemay, Mo.

DATE REC'D BY LOCAL REG. NOV 4 1951
REGISTRAR'S SIGNATURE: Earl Smith M.D.
25. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Fendler Und. Co. 7420 Michigan Av.

(Licensed Embalmer's Statement on Reverse Side)

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 Not Embalmed

Licensed Embalmer No. .....

P. O. Address O. E. Fendler

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.