

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

14435

State File No. ....  
Registrar's No. .... 3725

FILED MAY 1 - 1952

318

1003

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		State File 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 _____						
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St Louis Mo</u>		c. LENGTH OF STAY (in this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St Louis</u>		<u>2237</u>				
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>1735 Dolman Str.</u>				d. STREET ADDRESS (If rural, give location) <u>23</u> <u>1735 Dolman Str</u>						
3. NAME OF DECEASED (Type or Print) a. (First) <u>Stanley</u>			b. (Middle) _____			c. (Last) <u>Kaminski</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>4-19-52</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>4-9-1899</u>		9. AGE (In years last birthday) <u>53</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 10 HRS. Hours _____ Min. _____		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Roofer</u>			10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>St Louis Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>yes</u>			
13a. FATHER'S NAME <u>August Kaminski</u>			13b. MOTHER'S MAIDEN NAME <u>Anna Zielinska</u>			14. NAME OF HUSBAND OR WIFE <u>Bessie Kaminski</u>				
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. <u>495-18-9236</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Bessie Kaminski</u> ADDRESS <u>1735 Dolman</u>						
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <u>Coronary Thrombosis</u> <i>*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.</i>										
MEDICAL CERTIFICATION										
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) _____										
ANTECEDENT CAUSES Morbid conditions, if any, giving DUE TO (b) _____ rise to the above cause (a) stating the underlying cause last. DUE TO (c) _____										
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Chronic Myocarditis</u>										
INTERVAL BETWEEN ONSET AND DEATH <u>3 Mo.</u>										
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) _____ m. _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>H-201</u>						
22. I hereby certify that I attended the deceased from <u>9-14</u> , 19 <u>49</u> , to <u>4-19</u> , 1952, that I last saw the deceased alive on <u>4-21</u> , 1952, and that death occurred at <u>6:47</u> m., from the causes and on the date stated above.										
23a. SIGNATURE <u>Louis Bauer M.D.</u> (Degree or title)				23b. ADDRESS <u>2646 Gravois Ave</u>			23c. DATE SIGNED <u>4-21-52</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>B</u>		24b. DATE <u>4-22-52</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>St Louis Mo</u>				
DATE REC'D BY LOCAL REG. <u>APR 21 1952</u>		REGISTRAR'S SIGNATURE <u>Carl Smith MD</u>			25. FUNERAL DIRECTOR'S SIGNATURE <u>Central Funeral Home</u> ADDRESS <u>1841 Cass</u>					

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

mdb

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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.....

..... Student Embalmer No. ....

working under my personal supervision.

Student .....

Student Embalmer

Signed

*Robert M. Murray*

Licensed Embalmer No. *3749*

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.