

STANDARD CERTIFICATE OF DEATH

State File No. **14663**  
**3246**

FILED APR 25 1952

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
b. CITY OR TOWN <b>ST LOUIS MO</b>		c. CITY OR TOWN <b>St Louis</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>4934 Beacon ST</b>		d. STREET ADDRESS (If rural, give location) <b>4934 Beacon St</b>	

3. NAME OF DECEASED a. (First) <b>Michael</b>		b. (Middle) <b>Polka</b>		c. (Last)		4. DATE OF DEATH (Month) (Day) (Year) <b>4 4 - 52</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>married</b>	8. DATE OF BIRTH <b>Sept 29, 1923</b>		9. AGE (In years last birthday) <b>78</b>	10. MONTHS <b>6</b>	11. DAYS <b>5</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>		11. BIRTHPLACE (City and State or Foreign Country) <b>Poland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	

13a. FATHER'S NAME <b>unknown</b>		13b. MOTHER'S MAIDEN NAME <b>unknown</b>		14. NAME OF HUSBAND OR WIFE <b>Margaret</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>no</b>		17. INFORMANT'S SIGNATURE OR NAME <b>Maria Sztukowski</b>	
				ADDRESS <b>4934 Beacon</b>	

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) <b>Cerebral Haemorrhage</b>		DUE TO (b) <b>Hypertension</b>			<b>few hours</b>	
ANTECEDENT CAUSES		DUE TO (c) <b>Arteriosclerosis</b>			?	
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		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 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)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <b>331X</b>		

22. I hereby certify that I attended the deceased from **April 2, 1952**, to **April 4, 1952**, that I last saw the deceased **at home** on **April 4, 1952**, and that death occurred at **10:30 P. M.**, from the causes and on the date stated above.

23a. SIGNATURE <b>Robert G. W. Elean</b>		23b. ADDRESS <b>4356 Warne Avenue (7)</b>		23c. DATE SIGNED <b>4-7-52</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE <b>4/8/52</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Calvary</b>	
				24d. LOCATION (City, town, or county) (State) <b>St Louis Mo</b>	

DATE REC'D BY LOCAL REG. <b>APR 7 1952</b>		REGISTRAR'S SIGNATURE <b>Chas. Smith</b>		FUNERAL DIRECTOR'S SIGNATURE <b>St Louis Funeral Home</b>	
				ADDRESS <b>2205 St Louis Ave</b>	

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

1-97301

4356 W. Hill

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 John J. Harris

Licensed Embalmer No. 4418

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.