

THE DIVISION OF HEALTH OF THE STATE OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **45170**

FILED JAN 26 1953

REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

Registrar's No. **12171**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give town or township) <b>St. Louis, Missouri</b>		c. CITY (If outside corporate limits, write RURAL and give township) <b>St. Louis</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>St. Louis City Hospital #1</b>		d. STREET ADDRESS (If rural, give location) <b>25 6 North Whaff</b>	
3. NAME OF DECEASED (Type or Print) a. (First) <b>JOHN</b> b. (Middle) c. (Last) <b>WOLONKOWSKI</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>December 24, 1952</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widower</b>	8. DATE OF BIRTH <b>Unknown</b>
9. AGE (In years last birthday) <b>73</b>		10. MONTHS <b>73</b>	10. DAYS <b>73</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unknown</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) <b>Austria 4</b>
11. CITIZEN OF WHAT COUNTRY		12. CITIZEN OF WHAT COUNTRY	
13a. FATHER'S NAME <b>Unknown</b>		13b. MOTHER'S MAIDEN NAME <b>Unknown</b>	14. NAME OF HUSBAND OR WIFE <b>Unknown</b>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Unknown</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Hospital Record</b>
17. ADDRESS		17. ADDRESS	
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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Cerebrovascular Thrombosis</b>		DUE TO (b) <b>Arteriosclerosis</b>	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (c)		DUE TO (c) <b>Early gangrene of left leg</b>	
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) (m.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR	<b>332X</b>
22. I hereby certify that I attended the deceased from <b>December 9, 1952</b> , to <b>December 24, 1952</b> , that I last saw the deceased alive on <b>December 24, 1952</b> , and that death occurred at <b>5:55 P. m.</b> , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) <b>W. M. Higgins, M.D.</b>		23b. ADDRESS <b>1515 Lafayette Avenue</b>	23c. DATE SIGNED <b>12-26-52</b>
24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE <b>1-31-53</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Anatomical Board</b>	24d. LOCATION (City, town, or county) (State) <b>St. Louis, Mo.</b>
DATE REC'D BY LOCAL REG. <b>JAN 8 1953</b>	REGISTRAR'S SIGNATURE <b>J. C. Smith, M.D.</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>Rowland Mortuary Service</b>	
25. ADDRESS		25. ADDRESS <b>414 Manchester Ave.</b>	

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

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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.....

Licensed Embalmer No.....

P. O. Address.....

**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.**