

FILED APR 29 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

13133

Registrar's No.

3658

BIRTH NO.

REG. DIST. NO.

318

PRIMARY REG. DIST. NO.

1003

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MISSOURI</u> b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>ST. LOUIS, MISSOURI</u>		c. LENGTH OF STAY (In this place) c. CITY OR TOWN <u>St. Louis</u>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>ST. LOUIS CITY HOSPITAL</u>		e. STREET ADDRESS (If rural, give location) <u>6056 Thekla Ave 2079</u>	
3. NAME OF DECEASED a. (First) <u>JACOB</u> (Type or Print)		b. (Middle) <u>J.</u>	c. (Last) <u>BACZKOWSKI</u>
4. DATE OF DEATH (Month) (Day) (Year) <u>APRIL 22, 1954</u>		5. SEX <u>MALE</u>	
6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	
8. DATE OF BIRTH <u>Feb. 2, 1880</u>		9. AGE (In years last birthday) <u>74</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Grave Digger</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Cemetery</u>	
11. BIRTHPLACE (City and State or Foreign Country) <u>Poland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>John Baczkowski</u>		13b. MOTHER'S MAIDEN NAME <u>Maerie Gaultik</u>	
14. NAME OF HUSBAND OR WIFE <u>Catherine Baczkowski</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>494-24-7656</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Walker Baczkowski</u>	
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.		19. MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>cerebral arteriosclerosis</u> ANTECEDENT CAUSES <u>Diabetes mellitus</u> Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>intermittent bronchotracheitis 3 mths</u>	
19a. DATE OF OPERATION <u>1-21-54</u>		19b. MAJOR FINDINGS OF OPERATION <u>benign hypertrophy prostate</u>	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		21. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21c. CITY, TOWN, OR TOWNSHIP (COUNTY) (STATE) <u>260X</u>	
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		22. I hereby certify that I attended the deceased from <u>1-1-54</u> , 19 <u>54</u> , to <u>4-22-54</u> , 19 <u>54</u> , that I last saw the deceased alive on <u>4-22-54</u> , 19 <u>54</u> , and that death occurred at <u>11:00A</u> m., from the causes and on the date stated above.	
23a. SIGNATURE <u>[Signature]</u>		23b. ADDRESS <u>1515 Lafayette Avenue</u>	
23c. DATE SIGNED <u>4-22-54</u>		24a. RURAL, CREMATION REMOVAL (Specify)	
24b. DATE <u>4-26-54</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>	
24d. LOCATION (City, town, or county) (State) <u>St. Louis, Mo.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>John Skycak & Son</u>	
DATE REC'D BY LOCAL REG. <u>APR 23 1954</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>	
ADDRESS <u>554 Riverview</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>John Skycak & Son</u>	

(Licensed Embalmer's Statement on Reverse Side)

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, Student Embalmer No..... working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed..... *J. Allen Davis*

Licensed Embalmer No. *40*

P. O. Address *St L*

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 embalmed by a **STUDENT**, he also shall sign in his **OWN** handwriting.
If this body is not embalmed, fact should be so stated above.