

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

State File No. **24238**

Registrar's No. **7010**

FILED AUG 6 - 1954

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

BIRTH NO.		REG. DIST. NO.		PRIMARY REG. DIST. NO.		Registrar's No.		
1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).				
a. COUNTY				a. STATE		b. COUNTY		
b. CITY (If outside corporate limits, write RURAL and give township)				c. CITY OR TOWN		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>		
c. LENGTH OF STAY (In this place)				St. Louis		St. Louis		
d. FULL NAME OF HOSPITAL OR INSTITUTION				e. STREET ADDRESS (If rural, give location)				
2217 Howard St.				2209 20 2217 Howard St.				
3. NAME OF DECEASED			4. DATE OF DEATH					
a. (First)			b. (Middle)			c. (Last)		
Pauline			Barcikowski			7 28 54		
5. SEX		6. COLOR OR RACE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)		8. DATE OF BIRTH		
F		W.		Married		1-8-1889		
9. AGE (In years last birthday)		# UNDER 1 YEAR		# UNDER 1 YEAR		# UNDER 1 YEAR		
65		Months		Days		Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				11. BIRTHPLACE (City and State or Foreign Country)				
Housewife				Poland				
10b. KIND OF BUSINESS OR INDUSTRY				12. CITIZEN OF WHAT COUNTRY?				
				U.S.A.				
13a. FATHER'S NAME			13b. MOTHER'S MAIDEN NAME			14. NAME OF HUSBAND OR WIFE		
Frank Muzyczka			Oleksinska			Walter Barcikowski		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO.			17. INFORMANT'S SIGNATURE OR NAME		
(If yes, give war or dates of service)						Walter Barcikowski 2217 Howard		
MEDICAL CERTIFICATION								
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)				I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)				INTERVAL BETWEEN ONSET AND DEATH
*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.				Cerebral Hemorrhage				
ANTECEDENT CAUSES				Hypertension				
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				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 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)		
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				
				331X				
22. I hereby certify that I attended the deceased from May 20, 1954, to July 28, 1954, that I last saw the deceased alive on July 26, 1954, and that death occurred at 10A m., from the causes and on the date stated above.								
23a. SIGNATURE (Degree or title)				23b. ADDRESS		23c. DATE SIGNED		
H. A. Whlemeyer M.D.				4362 Warner Ave		7/29/54		
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE		24c. NAME OF CEMETERY OR CREMATORY		24d. LOCATION (City, town, or county) (State)		
Burial		7-31-54		Calvary		St. Louis Mo.		
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE			25. FUNERAL DIRECTOR'S SIGNATURE (Name) ADDRESS			
JUL 29 1954		Carl Smith MO			St Louis General 2205 St. Louis Ave.			

(Licensed Embalmer's Statement on Reverse Side)

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

No. 300
10-48

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 *Robert M. Munn*.....

Licensed Embalmer No. *3749*.....

P. O. Address *St. Louis*.....

**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.**