

FILED AUG 2 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 25177

6753

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). a. STATE MISSOURI b. COUNTY _____			
b. CITY OR TOWN ST. LOUIS MO		c. LENGTH OF STAY (in this place) _____		c. CITY OR TOWN ST. LOUIS		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION 3113 S. 7th ST.				e. STREET ADDRESS (If rural, give location) 24 3113 S. 7th ST.			
3. NAME OF DECEASED (Type or Print) a. (First) MICHAEL b. (Middle) SADOWSKI c. (Last) _____			4. DATE OF DEATH (Month) (Day) (Year) JULY 20 1954				
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED		8. DATE OF BIRTH Sept. - 1878	
9. AGE (In years last birthday) 78		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED MACHINIST		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and State or Foreign Country) 4 POLAND	
12. CITIZEN OF WHAT COUNTRY? _____		13a. FATHER'S NAME UNKNOWN		13b. MOTHER'S MAIDEN NAME UNKNOWN		14. NAME OF HUSBAND OR WIFE MAGDALENE SADOWSKI	
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. _____		17. INFORMANT'S SIGNATURE OR NAME ADDRESS EMILIE SCHNEIDER 3113 S. 7th			
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral hemorrhage INTERVAL BETWEEN ONSET AND DEATH 4 wks * ANTECEDENT CAUSES DUE TO (b) Gen arteriosclerosis DUE TO (c) Senility 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) 3318			
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 Mo. , 19 54 , to 7/20/54 , 19 54 , that I last saw the deceased alive on 7/20/54 , 19 54 , and that death occurred at 1:15 P.m. , from the causes and on the date stated above.							
23a. SIGNATURE Haceen Hayes (Degree or title) M.D.				23b. ADDRESS 4021 Northline		23c. DATE SIGNED 7/20/54	
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24b. DATE JULY 23 1954		24c. NAME OF CEMETERY OR CREMATORY CALVARY CEM.		24d. LOCATION (City, town, or county) (State) ST. LOUIS MO	
DATE REC'D BY LOCAL REG. JUL 21 1954		REGISTRAR'S SIGNATURE Carl Smith MD		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Thomas Kutis 2906 Gladwin			

(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.....
James C. Hill

Licensed Embalmer No. *434*

P. O. Address *2506*

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.