

No. 300
10.48

FILED SEP 16 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

32171

State File No.

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 7834

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) <u>LIFE</u>	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>BARNES HOSPITAL</u>		f. STREET ADDRESS (If rural, give location) <u>1316 NO. 20TH ST.</u> <u>2219</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>JOSEPH</u> b. (Middle) <u>FRANK</u> c. (Last) <u>SCHODROWSKI</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>AUGUST 23, 1954</u>					
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>OCT. 26TH 1894</u>	9. AGE (In years last birthday) <u>59 YRS.</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hour _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FURNITURE-FINISHER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>DAU-FURNITURE.CO</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>ST. LOUIS - MO.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>

13a. FATHER'S NAME <u>FRANK - SCHODROWSKI</u>	13b. MOTHER'S MAIDEN NAME <u>MARY - MITULSKI</u>	14. NAME OF HUSBAND OR WIFE <u>FRANCES - SCHODROWSKI</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>(YES) W.W.I. AUG. 1915 TO OCT. 1920</u>	16. SOCIAL SECURITY NO. <u>489-09-6736</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Frances Schodrowski</u>	ADDRESS <u>1316 N 20th St</u>
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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.	MEDICAL CERTIFICATION: I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Myocardial infarction, posterior, acute</u> ANTECEDENT CAUSES DUE TO (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) _____ Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>3 mos.</u>
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19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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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) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>4200</u>

22. I hereby certify that I attended the deceased from 8-23, 1954, to 8-23, 1954, that I last saw the deceased alive on 8-23, 1954, and that death occurred at 12:55 Pm., from the causes and on the date stated above.

23a. SIGNATURE <u>C. Vermillion, M.D.</u> (Degree or title)	23b. ADDRESS <u>BARNES HOSPITAL</u>	23c. DATE SIGNED <u>8-24-54</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	24b. DATE <u>AUG. 26TH 1954</u>	24c. NAME OF CEMETERY OR CREMATORY <u>NATIONAL CEMETERY</u>	24d. LOCATION (City, town, or county) (State) <u>JEFFERSON - BKS. MO</u>
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DATE REC'D BY LOCAL REG. <u>AUG 24 1954</u>	REGISTRAR'S SIGNATURE <u>J. Earl Smith M.D.</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Brockland Und. Co.</u>	ADDRESS <u>1827 - HOGAN - ST.</u>
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(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 me....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed John J. Haines.....

Licensed Embalmer No. 4108.....

P. O. Address St. Paul.....

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.