

FILED OCT 20 1954
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THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **35826**
Registrar's No. **8579**

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

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

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MISSOURI b. COUNTY		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN 915 No. Grand Blvd. St. Louis, Mo.		c. LENGTH OF STAY (in this place) 53 DAYS	c. CITY OR TOWN ST. LOUIS		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 Veteran's Hospital			e. STREET ADDRESS (If rural, give location) 1263a Amherst		
3. NAME OF DECEASED (Type or Print) a. (First) JOSEPH b. (Middle) CASIMIR c. (Last) PIEKARSKI			4. DATE OF DEATH (Month) (Day) (Year) 9-18-54		
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH 3-28-24	9. AGE (In years last birthday) 30	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) REPAIRMAN		10b. KIND OF BUSINESS OR INDUSTRY EDISON RECORDERS	11. BIRTHPLACE (City and State or Foreign Country) ST. LOUIS, MISSOURI		12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME CASIMIR PIEKARSKI		13b. MOTHER'S MAIDEN NAME PELLA BUKOWSKI		14. NAME OF HUSBAND OR WIFE JANE PIEKARSKI	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or unknown) YES	(If yes, give year or dates of service) WWII	16. SOCIAL SECURITY NO. 487262495	17. INFORMANT'S SIGNATURE OR NAME ADDRESS VA HOSP. RECORDS, ST. LOUIS, MO.		
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)			MEDICAL CERTIFICATION		
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) GENERALIZED METASTATIC CARCINOMA			INTERVAL BETWEEN ONSET AND DEATH 4 MOS.		
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.			II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION 6-5-54			19b. MAJOR FINDINGS OF OPERATION CARCINOMA RIGHT KIDNEY		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) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 180x			
22. I hereby certify that VA attended the deceased from 7-27 , 1954 , to 9-18 , 1954 , and that death occurred at 9:05 a.m., from the causes and on the date stated above.					
23a. SIGNATURE William S. Welborn			23b. ADDRESS VAH, ST. LOUIS, MO.		23c. DATE SIGNED 9-18-54
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Sept. 22, 1954	24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery		24d. LOCATION (City, town, or county) (State) St. Louis, Mo.	
DATE REC'D BY LOCAL REG. SEP 20 1954	REGISTRAR'S SIGNATURE J. Carl Smith	FUNERAL DIRECTOR'S SIGNATURE J. Donnelly		ADDRESS 3840 Lindell Blvd.	

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 [Signature].....

Licensed Embalmer No. 46.....

P. O. Address 3840 Leland.....

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.