

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **10142**

FILED MAR 31 1955

REG. DIST. NO. **318**

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

Registrar's No. **2054**

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 St. Louis		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 Faith Hospital		STREET ADDRESS (If rural, give location) 5731 Amelia Ave.			
3. NAME OF DECEASED (Type or Print) Victoria		a. (First) Sawicki		b. (Middle)	
c. (Last)		4. DATE OF DEATH Mar 3 1955		(Month) (Day) (Year)	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	
8. DATE OF BIRTH Mar. 25 1892		9. AGE (In years last birthday) 62		IF UNDER 1 YEAR Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nursewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) Poland	
12. CITIZEN OF WHAT COUNTRY USA		13a. FATHER'S NAME Michael Arasim		13b. MOTHER'S MAIDEN NAME Anna Kolarska	
14. NAME OF HUSBAND OR WIFE John Sawicki		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT'S SIGNATURE OR NAME John Sawicki		ADDRESS 5731 Amelia			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral hemorrhage massive			INTERVAL BETWEEN ONSET AND DEATH 5 1/2 hrs
*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES Arteriosclerotic hypertension			DUE TO (b) since C.V. Disease
		DUE TO (c)			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)	
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? 443X	
22. I hereby certify that I attended the deceased from 3-1-55 19 55 , to 3-3 19 55 , that I last saw the deceased alive on 3-3 19 55 , and that death occurred at 10:45 Am. , from the causes and on the date stated above.					
23a. SIGNATURE Uyantas J. Gyzman		(Degree or title)		23b. ADDRESS 1901 Madison St. St. Louis Mo.	
23c. DATE SIGNED 3/4/55		24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 3-7-55	
24c. NAME OF CEMETERY OR CREMATORY Cabany Cemetery		24d. LOCATION (City, town, or county) (State) St. Louis Mo.		25. FUNERAL DIRECTOR'S SIGNATURE John Stogor	
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE MAR 5 1955		REGISTRAR'S SIGNATURE J. Carl Smith MD		ADDRESS San 5541 Riverview	

(Licensed Embalmer's Statement on Reverse Side)

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

0.300
0.48

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..... *J. M. Puster*

Licensed Embalmer No. *398*

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.