

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

10352

FILED MAR 31 1955

State File No.

318

1003

Registrar's No.

2307

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		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 (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		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 type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION Christian Hospital				STREET ADDRESS (If rural, give location) 5221 Wren Avenue. 2079			
3. NAME OF DECEASED (Type or Print) a. (First) STANLEY b. (Middle) WARDENSKI c. (Last)			4. DATE OF DEATH (Month) (Day) (Year) Mar. 12, 1955				
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Apr. 23, 1866		9. AGE (in years last birthday) 88	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Policemen		10b. KIND OF BUSINESS OR INDUSTRY St. L. Met. P.D.		11. BIRTHPLACE (City and State or Foreign Country) Poland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Unknown		13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE Julia Wardenski			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or date of service) no none		16. SOCIAL SECURITY NO. none		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. J. Wardenski 5221 Wren Avenue			
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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Arterio-sclerotic heart disease</u> <u>Coronary Occlusion</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) DUE TO (c) <u>Pneumonia Lobular</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Old age</u>				INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs</u> <u>2 days</u> <u>6 days</u>	
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? 4200			
22. I hereby certify that I attended the deceased from <u>Dec 1941</u> , to <u>March 12, 1955</u> , that I last saw the deceased alive on <u>3-12</u> , 1955 and that death occurred at <u>9:00 A</u> m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Nicholas Keyes M.D.</u>				23b. ADDRESS <u>3626-28 N. 11th</u>		23c. DATE SIGNED <u>3-12-55</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 3/15/55	24c. NAME OF CEMETERY OR CREMATORY Mt. Olive Cemetery		24d. LOCATION (City, town, or county) (State) St. Louis County, Mo.		
DATE REC'D BY LOCAL REG. MAR 14 1955		REGISTRAR'S SIGNATURE <u>J. Carl Smith M.D.</u> mfs		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS John Stygar & Son 5541 Riverview BL.			

WRITE PLAINLY—USING UNFAADING 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..... *J. W. Rister*

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.