

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED APR 6 - 1956

State File No. **11658**
Registrar's No. **3292**

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY	
b. CITY OR TOWN St. Louis		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"/>
c. LENGTH OF STAY (in this place)		e. STREET ADDRESS (If rural, give location) 5308 Gypsy	
d. FULL NAME OF HOSPITAL OR INSTITUTION DOA City Hospital			

3. NAME OF DECEASED (Type or Print)	a. (First) Walter	b. (Middle)	c. (Last) Wysocki	4. DATE OF DEATH (Month) (Day) (Year) March 30 1956
-------------------------------------	--------------------------	-------------	--------------------------	------------------------------------------------------------

5. SEX male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed	8. DATE OF BIRTH March 5 1879	9. AGE (in years last birthday) 77	IF UNDER 1 YEAR Months	IF UNDER 2 HRS. Hours	IF UNDER 15 MIN. Min.
--------------------	-------------------------------	-----------------------------------------------------------------------	--------------------------------------	-------------------------------------------	------------------------	-----------------------	-----------------------

10a. USUAL OCCUPATION (Give kind of work specifying most of working life, even if retired) Radiator repair	10b. KIND OF BUSINESS OR INDUSTRY building	11. BIRTHPLACE (City and State or Foreign Country) Poland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
-------------------------------------------------------------------------------------------------------------------	---------------------------------------------------	------------------------------------------------------------------	--------------------------------------------

13a. FATHER'S NAME Not Known	13b. MOTHER'S MAIDEN NAME Not Known	14. NAME OF HUSBAND OR WIFE Antonia Wysocki
-------------------------------------	--------------------------------------------	----------------------------------------------------

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	16. SOCIAL SECURITY NO. 066 14 1477	17. INFORMANT'S SIGNATURE OR NAME Lee Powers ADDRESS 9947 Norwich Dr.
--------------------------------------------------------------------------------------------------------------------	--------------------------------------------	-------------------------------------------------------------------------------------

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		INTERVAL BETWEEN ONSET AND DEATH minutes One year XX
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH Coronary thrombosis Congestive heart failure Glomerular Nephritis		
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. Glomerular Nephritis		DUE TO (b) Glomerular Nephritis	
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 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) 3-27-56	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 **Feb 1-56**, 1956 to **March 27, 1956**, that I last saw the deceased alive on **March 27, 1956**, and that death occurred at **DOA IOAN** from the causes and on the date stated above.

22a. SIGNATURE Guy Simpson (Degree or title)	22b. ADDRESS 634 N. Grand	23c. DATE SIGNED 4/2/56
-----------------------------------------------------	----------------------------------	--------------------------------

24a. BURIAL CREMATION REMOVAL (Specify) burial	24b. DATE 4/3/56	24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	24d. LOCATION (City, town, or county) (State) St. Louis Mo.
-------------------------------------------------------	-------------------------	------------------------------------------------------------	--------------------------------------------------------------------

DATE REC'D BY LOCAL REG. APR 2 1956	REGISTRAR'S SIGNATURE Charles Smith	25. FUNERAL DIRECTOR'S SIGNATURE Buchholz Mortuary ADDRESS 5967W. Florissant
--------------------------------------------	--------------------------------------------	--------------------------------------------------------------------------------------------

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING 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 examined

by me, or by, Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *Richard M. Burchette*.....
Licensed Embalmer No.....

P. O. Address *St. Louis*.....

Note: The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his **OWN HANDWRITING**. (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.