

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

22065

FILED JUN 29 1956

State File No.

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **5893**

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)	
b. CITY (If outside corporate limits, write RURAL and give town) OR TOWN St. Louis		c. LENGTH OF STAY (in this place) 34 yrs.	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis State Hospital		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
e. STREET ADDRESS (If rural, give location) 13 5400 Arsenal Street		c. CITY OR TOWN St. Louis	

3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH (Month) (Day) (Year)	
a. (First) Stanley	b. (Middle)	c. (Last) Pulwicz	June 21 1956
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced	8. DATE OF BIRTH 8-2-79
9. AGE (In years last birthday) 76	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 18 Hrs. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	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 Unknown	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Frances Cenarzewski
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) None	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME ANASTAZIA KONCZEWSKA
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		ADDRESS 1457 Benton

1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute pulmonary edema		INTERVAL BETWEEN ONSET AND DEATH One day
ANTECEDENT CAUSES		
Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		
DUE TO (b)		
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS		
Conditions contributing to the death but not related to the disease or condition causing death. Chronic heart disease		20 yrs.

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?

22. I hereby certify that I attended the deceased from 6-15-44, 1944, to 6-21, 1956, that I last saw the deceased alive on 6-21, 1956, and that death occurred at 5:40 a. m., from the causes and on the date stated above.

23a. SIGNATURE John H. McManus M.D.	23b. ADDRESS 5400 Arsenal Street	23c. DATE SIGNED 6-21-56
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE 6-22-56	24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery St. Louis Mo
24d. LOCATION (City, town, or county) (State)		

DATE REC'D BY LOCAL REG. JUN 21 1956	REGISTRAR'S SIGNATURE Charles Smith M.D.	25. FUNERAL DIRECTOR'S SIGNATURE JOHN STYGAR & SON	ADDRESS 5541 RIVERVIEW BLVD.
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* (Licensed Embalmer's Statement on Reverse Side)

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. Rester*

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.