

Health,  
Welfare  
Public  
Service

300  
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED NOV 8 1957

STATE FILE NUMBER  
38209  
10244

Registration District No. 318 Primary Registration District No. 1003 Registrar's No.

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>    </u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS Mo</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>ST. LOUIS</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>3522 MINNESOTA</u>				Length of stay in lb		d. STREET (If outside, give location) ADDRESS <u>3522 MINNESOTA</u>	
3. NAME OF DECEASED (Type or print) <u>MARY ANN BRANIECKI-SUCHARA</u>				4. DATE OF DEATH Month <u>OCT.</u> Day <u>29</u> Year <u>1957</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MAR. 11 1883</u>	
9. AGE (In years last birthday) <u>74</u>		IF UNDER 1 YEAR Months <u>    </u> Days <u>    </u> Hours <u>    </u> Min <u>    </u>		IF UNDER 24 HRS. Months <u>    </u> Days <u>    </u> Hours <u>    </u> Min <u>    </u>		11. BIRTHPLACE (City and state or country) <u>Poland</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>    </u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>FRANK SUCHARA</u> Address <u>3522 MINNESOTA</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1-2 hours</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						DUE TO (b) <u>Cerebral Hypertension</u> DUE TO (c) <u>Arteriosclerosis - Generalized</u> <u>331x</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>None</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <u>2</u>	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour . Month, Day, Year a. m. p. m.							
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from <u>Sept 1, 1955</u> to <u>Oct 29, 1957</u> and last saw her/him alive on <u>10/8/57</u> Death occurred at <u>6:35 AM</u> on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>Dr. Paul H. Whitcomb M.D.</u>				22b. ADDRESS <u>2905 Chamberlitt</u>		22c. DATE SIGNED <u>10/30/57</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>Nov. 2 1957</u>		23c. NAME OF CEMETERY OR CREMATORY <u>S. S. Peter &amp; Paul</u>		23d. LOCATION (City, town, or county) (State) <u>S. S. Peter &amp; Paul</u>	
24. FUNERAL DIRECTOR <u>Thomas Kutia 2906 Lewis</u>				25. DATE RECD. BY LOCAL REG. <u>OCT 31 57</u>		26. REGISTRAR'S SIGNATURE <u>Carl Smith MO</u> <u>mjs</u>	

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Fill & Print

PR 1-2428

2905

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 *Samuel C. Hill*

Licensed Embalmer No. *434*

P. O. Address *2906*

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.