

FILED DEC 30 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

465339  
STATE FILE NUMBER

Registration District No. 312 Primary Registration District No. 541 Registrar's No. 3092

5.  
1.

1. PLACE OF DEATH a. COUNTY <u>ST. LOUIS</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>CLAYTON</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>St. Louis -</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>46 ST. Louis County Hospital</u>		Length of stay in lb	d. STREET ADDRESS (If outside, give location) <u>2370 2253 INDIANA</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>ALEX</u> Middle Last <u>ATAMANCHEK</u>			4. DATE OF DEATH Month <u>DEC</u> Day <u>6</u> Year <u>1957</u>		
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAR. 15, 1886</u>	9. AGE (In years last birthday) <u>71</u>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED FURRIER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FURRIER</u>	11. BIRTHPLACE (City and state or country) <u>AUSTRIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U-S-A</u>
13a. FATHER'S NAME <u>ALEXANDER ATAMANCHEK</u>		13b. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>		14. NAME OF HUSBAND OR WIFE <u>Victoria ATAMANCHEK</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>unk</u>		17. INFORMANT Address <u>MARY WILDHABER 7091 COBBITT</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>CORONARY ARTERY OCCLUSION</u>					INTERVAL BETWEEN ONSET AND DEATH <u>ACUTE</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause lost. DUE TO (b) <u>ARTERIOSCLEROTIC HEART DIS.</u> <u>with Rt. BUNDLE BRANCH BLOCK</u> DUE TO (c) <u>AND INTRAVENTRICULAR CONDUCTION DEFECT</u>					<u>2 year</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>4200</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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 a.m. Month, Day, Year p.m.					
20d. INJURY OCCURRED WHILE AT <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>Nov. 19, 1957</u> to <u>DEC. 6, 1957</u> and last saw <sup>him</sup> alive on <u>NOV 21, 1957</u> Death occurred at <u>11 P.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>Henry Rosenfeld M.D.</u>			22b. ADDRESS <u>3903 OLIVE SAL 9</u>		22c. DATE SIGNED <u>DEC. 8, 1957</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BUCIAL</u>		23b. DATE <u>Dec. 9, 1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Sunset Burial</u>		23d. LOCATION (City, town, or county) (State) <u>St. Louis County, Mo.</u>
24. FUNERAL DIRECTOR <u>Thomas Kulis</u>		ADDRESS <u>2906 Leavis</u>		25. DATE RECD. BY LOCAL REG. <u>12-8-57</u>	26. REGISTRAR'S SIGNATURE <u>Herbert Blanche MD</u> <u>Rec</u>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

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.

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 *Leo J. Budde*

Licensed Embalmer No. *3989*

P. O. Address *St. Louis, Mo.*

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.