

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-030457  
STATE FILE NUMBER

FILED SEP 8 1958 Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 8325

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, give TOWNSHIP only) OR TOWN ST. LOUIS, MO.		c. CITY OR TOWN ST. LOUIS	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. LOUIS CITY HOSPITAL #1		d. STREET ADDRESS (If outside, give location) 126 1/2 1515 CLINTON ST	
3. NAME OF DECEASED (Type or print) First Middle Last STELIA T. L. GRZYB		4. DATE OF DEATH Month Day Year 8-26-58	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPT. 29 TH 1887
9. AGE (In years last birthday) 40		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE	11. BIRTHPLACE (City and state or country) POLAND
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. NAME OF HUSBAND OR WIFE WALTER GRZYB (DECD)	
14. FATHER'S NAME WALTER GRZYB		15. MOTHER'S MAIDEN NAME UNKNOWN	
16. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO NONE		17. SOCIAL SECURITY NO. 490-12-6428A	
18. CAUSE OF DEATH (Enter only one cause per line for (a); (b); and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction		19. INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)		420.1	
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		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 Month, Day, Year a.m. 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 Death occurred at 8:10 P.M. on the date stated above; and to the best of my knowledge, from the causes stated.		and last saw her/him alive on 8-26-58	
22a. SIGNATURE (Degree or title) Cornelius J. Connor, M.D.		22b. ADDRESS 1515 LAFAYETTE AVE	
22c. DATE SIGNED 8-26-58			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE AUG. 29 TH 1958	
23c. NAME OF CEMETERY OR CREMATORY CALVARY CEMETERY		23d. LOCATION (City, town, or county) (State) ST. LOUIS - MISSOURI	
24. FUNERAL DIRECTOR Brockland and Co. 1827 HOGAN ST		25. DATE RECD. BY LOCAL REG. AUG 28 '58	
26. REGISTRAR'S SIGNATURE J. Carl Smith, M.D.			

All diseases in Part I must be causally related.  
 Donor, coroner, etc. must use shiny standard nomenclature in item 18. No symptoms will be listed.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
 MEDICAL CERTIFICATION

(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

*Robert J. Marra*

Licensed Embalmer No. 3749

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.