

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-011709

STATE FILE NUMBER

FILED MAR 19 1959 Registration District No. 317 Primary Registration District No. 547 Registrar's No. 705

300
1-57

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Clayton Rich. Hts.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN University City Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Mary's Hospital		Length of stay in lb 4 days	d. STREET ADDRESS (If outside, give location) 6826 Washington Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last Nikolaus Leonard Dunin-Brzezinski			4. DATE OF DEATH Month Day Year March 14, 1959		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 27, 1886		9. AGE (In years, months, and days) 72 IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance Engineer		10b. KIND OF BUSINESS OR INDUSTRY Washington University		11. BIRTHPLACE (City and state or country) Caucasus, Russia	
12. CITIZEN OF WHAT COUNTRY? U.S.					

13a. FATHER'S NAME Leonard Dunin-Brzezinski		13b. MOTHER'S MAIDEN NAME Maria Unknown		14. NAME OF HUSBAND OR WIFE Zinaida Brzezinski	
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. 080-28-0020A		17. INFORMANT Address Zinaida Brzezinski, 6826 Washington	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis		INTERVAL BETWEEN ONSET AND DEATH 4 days
DUE TO (b) Cerebral Vascular disease		
DUE TO (c) _____		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Diabetes mellitus		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) 332x	
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.) 332x	
20f. CITY, TOWN, OR LOCATION St. Louis		COUNTY STATE Mo.	

21. I attended the deceased from **March 10** to **Mar 14** and last saw ^{her} _{him} alive on **3/14/59**
Death occurred at **8:00 pm** on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE E. J. Klein schmidt M.D.	(Degree or title)	22b. ADDRESS 508 N. Grand Ave	22c. DATE SIGNED 3/16/59
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 3-17-59	23c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis Co., Mo.
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24. FUNERAL DIRECTOR Albert H. Hoppe, 4700 Washington Blvd.	ADDRESS	25. DATE RECD. BY LOCAL REG 3-17-59	26. REGISTRAR'S SIGNATURE John L. Murphy, M.D.
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All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *W. W. Wilkinson*

Licensed Embalmer No. *3575*

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.