

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-016339
STATE FILE NUMBER

FILED MAY 8 1959 Registration District No. 317 Primary Registration District No. 500 Registrar's No. 1179

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 Lemay, Missouri		c. CITY OR TOWN Lemay 4000	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 9353 So. Broadway		d. STREET ADDRESS 9353 So. Broadway	

3. NAME OF DECEASED (Type or print) First Mary Middle - Last Pawlikowski			4. DATE OF DEATH Month April Day 29 Year 1959		
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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. 20, 1866	9. AGE (In years last birthday) 92	IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	IF UNDER 24 HRS. Hours 0 Min. 0
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (City and state or country) Ukrainia	12. CITIZEN OF WHAT COUNTRY? U. S. A.
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13. FATHER'S NAME Unknown	14. MOTHER'S MAIDEN NAME Unknown
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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. None	17. INFORMANT Marie Bush, 100 Sheldon Drive
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) arterio sclerotic heart disease		INTERVAL BETWEEN ONSET AND DEATH ?	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Generalized arterio sclerosis		?
	DUE TO (c) Senility		
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.) None	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20c. TIME OF INJURY Hour 5 Month 4 Day 5 Year 1959	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.) Home	20f. CITY, TOWN, OR LOCATION St. Louis	COUNTY Mo	STATE Mo
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21. I attended the deceased from March 7 1959 to April 29 1959 and last saw her alive on April 28 1959 Death occurred at 5 A m on the date stated above; and to the best of my knowledge, from the causes stated.		22a. SIGNATURE Max Starbuck M.D.	22b. ADDRESS 512 Drew Place	22c. DATE SIGNED 4/29/59
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23a. TIME OF BURIAL Burial	23b. DATE May 2, 1959	23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	23d. LOCATION (City, town, or county) St. Louis	STATE Missouri
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24. FUNERAL DIRECTOR JOHN STYGAR & SON FUNERAL HOME	ADDRESS 5541 RIVERVIEW BOULEVARD	25. DATE RECD. BY LOCAL REG. 4-29-59	26. REGISTRAR'S SIGNATURE John C. Murphy M.D.
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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diseases in Part must be causally related. Coroner cannot certify to a death due to natural causes.

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. Ruster
Licensed Embalmer No. 39

P. O. Address *St. Louis*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING.
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.