Health, Welfare Public Service

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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-019528
STATE FILE NUMBER

FILED JUN 1 1959 Registration District No. ..... Primary Registration District No. ..... Registrar's No. 2 4732

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Louis — Inside Limits: Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): 4934 Beacon — Length of stay in 1b

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri
b. COUNTY
c. CITY OR TOWN: St. Louis — Inside Limits: Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location): 4934 Beacon — Reside on Farm: Yes [ ] No [X]

3. NAME OF DECEASED (Type or print): First: Margaret — Middle: — Last: Polka

4. DATE OF DEATH: Month 5 Day 13 Year 59

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]
8. DATE OF BIRTH: 5-21-1872
9. AGE (In years at last birthday): 86 — 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): Housewife
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and state or country): Poland
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13a. FATHER'S NAME: Unknown
13b. MOTHER'S MAIDEN NAME: Unknown
14. NAME OF HUSBAND OR WIFE: Michael Polka

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: —
17. INFORMANT: Marie Sztukowski — Address: 4934 Beacon

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Occlusion.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c): 420.1
INTERVAL BETWEEN ONSET AND DEATH

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 [ ] NO [X]

20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]
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. p.m. — Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
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 Jan. 10 58, to May 10 and last saw her/him alive on May 10 59
Death occurred at May 13 59 m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: J. J. Vygard (Degree or title) MD
22b. ADDRESS: 3511 Vincennes
22c. DATE SIGNED: 5-14-59

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 5-16-59
23c. NAME OF CEMETERY OR CREMATORY: Calvary
23d. LOCATION (City, town, or county) (State): St. Louis, Missouri

24. FUNERAL DIRECTOR: ST. LOUIS FUNERAL HOME — ADDRESS: 2205 St. Louis Ave.
25. DATE RECD. BY LOCAL REG.: MAY 15 '59
26. REGISTRAR'S SIGNATURE: Neal Smith, M.D.
(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 Elmo R. Padwell

Licensed Embalmer No. 4077

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.