

FEDERAL BUREAU OF INVESTIGATION - STANDARD CERTIFICATE OF DEATH

59-037951

FILED VS OCT 28 1959

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **2 9520**

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		Length of stay in 1b LIFE	c. CITY OR TOWN ST. LOUIS		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. JOHN'S-HOSPITAL		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 5538 WEST. FLORISSANT-AV.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) EMILIA First PIEKARSKI. Middle Last			4. DATE OF DEATH OCT. 15TH 1959 Month Day Year		
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 4-16-1883	9. AGE (last birthday) 76 YRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE-WORK		10b. KIND OF BUSINESS OR INDUSTRY HOME	11. BIRTHPLACE (City and state or country) ST. LOUIS - MO.	12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME ANDREW-PIEKARSKI		13b. MOTHER'S MAIDEN NAME CATHERINE-WAWROCKA		14. NAME OF HUSBAND OR WIFE NEVER-MARRIED	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO NONE		16. SOCIAL SECURITY NO. NONE	17. INFORMANT Address PELLA-GORSKI-5538 W. FLORISSANT-AV.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:					INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) Food-operative shock					24 hours
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					
DUE TO (b) Carcinomatosis (Lung + Lymph Nodes).					6 months.
DUE TO (c) Carcinoma of Caecum 153.0					8-12 months.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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. p.m.	Month, Day, Year				
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.)	20f. CITY, TOWN, OR LOCATION	COUNTY	STATE	
21. I attended the deceased from 10-7-59 to 10-15-59 and last saw her/him alive on 10-15-59 Death occurred at 4:45 P. m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) Joseph T. Dmytryk, M.D.			22b. ADDRESS University Club Bldg		22c. DATE SIGNED 10-16-59
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE OCT. 19-1959	23c. NAME OF CEMETERY OR CREMATORY CALVARY-CEMETERY	23d. LOCATION (City, town, or county) ST. LOUIS	(State) MO.	
24. FUNERAL DIRECTOR Brockland Und. Co. - 1827-HOGAN-ST.		ADDRESS	25. DATE RECD. BY LOCAL REG. OCT 17 59	26. REGISTRAR'S SIGNATURE Koal Smith, M.D.	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Elmo R. Padu

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.