

# URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

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STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. **211940**

ENDED

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Length of stay in 1b <b>6 weeks</b>		c. CITY OR TOWN <b>St. Louis</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Missouri Baptist Hospital</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>4516a Strodtman Place</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>p</b> Last <b>Glowacki</b>			4. DATE OF DEATH Month <b>Dec.</b> Day <b>22</b> Year <b>1959</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>white</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>7-8-1920</b>	9. AGE (last birthday) <b>39</b>	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machinist</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Stile-Craft Mfgs</b>		11. BIRTHPLACE (City and state or country) <b>St. Louis, Missouri</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>Francis Glowacki</b>			13b. MOTHER'S BIRTH NAME <b>(Venetian Brinds)</b>		14. NAME OF HUSBAND OR WIFE <b>Bessie Glowacki</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>489-05-4734</b>		17. INFORMANT Address <b>Mrs. Bessie Glowacki, 4516a Strodtman Pl</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Plasma Cell myeloma of spinal cord Thoracic T-1 + T-2 with general metastasis</b> DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>12/28/59</b> PART III. If deceased was female was there a pregnancy in last 90 days. <b>203x</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown						
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input checked="" 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.) <b>While in car struck from behind by vehicle</b>				
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year <b>12 14 58</b>	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> <b>?</b>					
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>?</b>		20f. CITY, TOWN, OR LOCATION <b>?</b>		COUNTY _____ STATE _____		
21. I attended the deceased from <b>12-26-58</b> to <b>12-22-59</b> and last saw her/him alive on <b>12-22-59</b> Death occurred at <b>10:15 pm</b> m on the date stated above, and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE (Deceased or file) <b>Clarence H. Kulker M.D.</b>			22b. ADDRESS <b>3121 Norand St. Louis Mo</b>		22c. DATE SIGNED <b>12-24-59</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>12-26-1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Buck Road Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Glen Carbon, Illinois</b>		
24. FUNERAL DIRECTOR <b>Math Hermann &amp; Son, Inc., 2161 E. Fair Av</b>			25. DATE RECD. BY LOCAL REG. <b>DEC 24 1959</b>	26. REGISTRAR'S SIGNATURE <b>Earl Smith, M.D.</b>		

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 Welford H Burnley

Licensed Embalmer No. 4202

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.