

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-004651

FILED VS. FEB 15 1960 317

Registration District No. 500 Primary Registration District No. 500 Registrar's No. 283

STATE FILE NUMBER

DEED

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 Normandy		Length of stay in 1b 5 Months	c. CITY OR TOWN St. Ann Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Shamrock Nursing Home		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 11009 Modesto Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Catherine Middle Wawrzyniak Last			4. DATE OF DEATH Month Jan Day 27 Year 1960		
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 11/18/1904	9. AGE (last birthday) 65	IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY At Home	11. BIRTHPLACE (City and state or country) Poland	12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME John Stodkiewicz		13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE The Late MAX wawrzyniak	
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 Address Max Wawrzyniak 11009 Modesto		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction		INTERVAL BETWEEN ONSET AND DEATH 1 day
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Arteriosclerotic Cardiovascular		unknown
DUE TO (c) Diabetes mellitus		unknown

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 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.)	
20c. TIME OF INJURY Hour Month, Day, Year 3:40 A m on Aug 1, 1959			

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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 **Aug 1, 1959** to **Jan 27, 1960** and last saw her **alive** on **Jan 25, 1960**
Death occurred at **3:40 A m** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Lewis Seltmann MD	22b. ADDRESS 8231 Clayton Rd (17)	22c. DATE SIGNED 1/27/60
--	---	------------------------------------

23a. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	23b. DATE 1)30)1960	23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	23d. LOCATION (City, town, or county) St. Louis, Mo.
---	-------------------------------	---	--

24. FUNERAL DIRECTOR ADDRESS Collier Mortuary, St. Ann, Mo.	25. DATE RECD. BY LOCAL REG. 1-28-60	26. REGISTRAR'S SIGNATURE James M. Wawrzyniak 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 Sheldon Collier

Licensed Embalmer No. 338

P. O. Address St. Ann

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.