URI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS APR 12 1960

60-013095

STATE FILE NUMBER

ENDED

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 2 3663

1. PLACE OF DEATH
a. COUNTY

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo. b. COUNTY

b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis | Length of stay in 1b

c. CITY OR TOWN St. Louis | Inside Limits Yes ☒ No ☐

c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 3419 Gasconade St. | Inside Limits Yes ☒ No ☐

d. STREET ADDRESS (If outside, give location) 3419 Gasconade St. | Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print) First Middle Last: Sister M. Theophila Pudlowski O.S.F.

4. DATE OF DEATH Month Mar. Day 29 Year 1960

5. SEX Female | 6. COLOR OR RACE White | 7. Married ☐ Never Married ☒ Widowed ☐ Divorced ☐ | 8. DATE OF BIRTH 8/8/1877 | 9. AGE (last birthday) 82 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HR Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher | 10b. KIND OF BUSINESS OR INDUSTRY Convent | 11. BIRTHPLACE (City and state or country) Poland | 12. CITIZEN OF WHAT COUNTRY U.S.A.

13a. FATHER'S NAME Francis Pudlowski | 13b. MOTHER'S MAIDEN NAME Angelica Ligmanowski | 14. NAME OF HUSBAND OR WIFE None

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) XXXX (If yes, give war or dates of service) XXXXXXX | 16. SOCIAL SECURITY NO. None | 17. INFORMANT Our Lady of Perpetual Help Address 3419 Gasconade St.

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) Arteriosclerotic Heart Disease | INTERVAL BETWEEN ONSET AND DEATH 1957

DUE TO (b) Acute Cardiac Failure | 3 Days

DUE TO (c) Acute Pulmonary Passive Congestion | 3/16/60

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 420.0

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☒ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

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 10/57, to 3/29/60 and last saw her alive on 3/23/60

Death occurred at 11:20 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

BY AFFIDAVIT OF

22a. SIGNATURE George J. Mehan MD (Degree or title) | 22b. ADDRESS 3903 Olive | 22c. DATE SIGNED 3/31/60

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE 4/1/1960 | 23c. NAME OF CEMETERY OR CREMATORY Villa St. Joseph Cem. | 23d. LOCATION (City, town, or county) Ferguson (State) Mo.

24. FUNERAL DIRECTOR ADDRESS JOHN STYGAR & SON – 5541 RIVERVIEW BLVD. | 25. DATE RECD. BY LOCAL REG. MAR 31 1960 | 26. REGISTRAR'S SIGNATURE Earl Smith, M.D. MJC

(Licensed Embalmer's Statement on Reverse Side)

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_____ Signed J. W. Ristec

Signature of Student Embalmer

Licensed Embalmer No. 3980

P. O. Address St Louis

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