

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-004039

FILED VS FEB 14 1961

AMENDED ✓

Registration District No. 217 Primary Registration District No. 547 Registrar's No. 312

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Richmond Heights</u>		Length of stay in 1b <u>3 Wks 5 das</u>	c. CITY OR TOWN <u>Greendale La.</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Mary's Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>7449 Marillac Dr.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <u>WILLIAM FREDRICK SKROSKA</u>			4. DATE OF DEATH Month Day Year <u>Jan. 30, 1961</u>			
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>5/10/01</u>	9. AGE (last birthday) <u>59</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mail carrier</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>US Postal service</u>	11. BIRTHPLACE (City and state or country) <u>St. Louis Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
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13a. FATHER'S NAME <u>Joseph Skroska</u>	13b. MOTHER'S MAIDEN NAME <u>Mary Ann Wieners</u>	14. NAME OF HUSBAND OR WIFE <u>Della Schuettenberg</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>	16. SOCIAL SECURITY NO.	17. INFORMANT Address <u>Della Skroska 7449 Marillac Dr.</u>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BRONCHOGENIC CA</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 mos</u>
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Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		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)			
PART III. If deceased was female was there a pregnancy in last 90 days. <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 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.)
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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
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21. I attended the deceased from 11-3-60 to 1-30-61 and last saw him alive on 1-30-61  
Death occurred at 10:00 P on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Regree or title) <u>William Bellegric MD</u>	22b. ADDRESS <u>3720 Washington</u>	22c. DATE SIGNED <u>1-31-61</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>Feb. 2, 61.</u>	23c. NAME OF CEMETERY OR CREMATORY <u>S.S. Peter &amp; Paul Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>St. Louis Mo.</u>
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24. FUNERAL DIRECTOR <u>Calvin Kelly</u>	ADDRESS <u>7267 Natural Bridge</u>	25. DATE RECD. BY LOCAL REG. <u>2-1-61</u>	26. REGISTRAR'S SIGNATURE <u>J. C. Murphy M.D.</u>
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DATE AMENDED  
AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
INSTEAD OF  
MEDICAL CERTIFICATION  
BY AFFIDAVIT OF  
ITEM NO. SHOULD READ

DOCUMENT

**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 James A. Lammons

Licensed Embalmer No. 4142

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.