

SOUR DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-019420
STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **4853**

AMENDED

DATE AMENDED

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

LED JUN 2 1961

1. PLACE OF DEATH
a. COUNTY _____
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN **St. Louis** Length of stay in 1b _____
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION **Luthern Hosp** Inside Limits Yes No

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE **Mo** b. COUNTY **St. Louis**
c. CITY OR TOWN **Aftton, Mo** Inside Limits Yes No
d. STREET ADDRESS (If outside, give location) **6521 Saybrook Dr.** Reside on Farm Yes No

3. NAME OF DECEASED First Middle Last 4. DATE OF DEATH Month Day Year
Jessie A Romanowaki **5/20/61**

5. SEX **female** 6. COLOR OR RACE **white** 7. Married Never Married Widowed Divorced 8. DATE OF BIRTH **10/26/64** 9. AGE (last birthday) **96** 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) **housework** 10b. KIND OF BUSINESS OR INDUSTRY _____ 11. BIRTHPLACE (City and state or country) **St. Louis, Mo** 12. CITIZEN OF WHAT COUNTRY **USA**

13a. FATHER'S NAME **William Greig** 13b. MOTHER'S MAIDEN NAME **Elizabeth Torrance** 14. NAME OF HUSBAND OR WIFE **Hugh Romanowaki**

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. **unk** 17. INFORMANT **Ada Prichard** Address **6521 Saybrook Dr.**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH CAUSED BY:
IMMEDIATE CAUSE (a) **Cardiac failure**
Conditions, (if any), which gave rise to above cause (b) **Fracture of hip**
Underlying cause (c) **902.7-45**

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. 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.) **fell out of a wheel chair at Bethesda**

20c. TIME OF INJURY Hour s.m. p.m. Month, Day, Year **5-18-61**

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.) **at Bethesda Hosp** 20f. CITY, TOWN, OR LOCATION **St Louis** COUNTY **MO** STATE **MO**

21. I attended the deceased from **May 18** to **May 20-61** and last saw her/him alive on **May 19-61**
Death occurred at **Luthern Hosp** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) **Stanley M. Leydig M.D.** 22b. ADDRESS **16 Hampton Village Plaza** 22c. DATE SIGNED **5/22/61**

23a. BURIAL, CREMATION, REMOVAL (Specify) **removal** 23b. DATE **5/23/61** 23c. NAME OF CEMETERY OR CREMATORY **Sunset burial park** 23d. CITY, TOWN, OR COUNTY (State) **St. Louis, Mo**

24. FUNERAL DIRECTOR **Edward Fendler** ADDRESS **5611 South Grand Blvd.** 25. DATE RECD. BY LOCAL REG. **MAY 23 1961** 26. REGISTRAR'S SIGNATURE **Loan Smith M.D.**

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 *LeRoy B. Busch*

Licensed Embalmer No. 3989

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.