SSOURI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

-61-022323
STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 5463

AMENDED

FILED JUN 16 1961

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF

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: 1514 Warren St. Inside Limits Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mo. b. COUNTY
c. CITY OR TOWN: St. Louis Inside Limits Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location): 1514 Warren St. Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First Katherine Middle Boczek Last
4. DATE OF DEATH: Month June Day 12 Year 1961
5. SEX: Female
6. COLOR OR RACE: White
7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐
8. DATE OF BIRTH: 5-11-1876
9. AGE (last birthday): 85
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): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (City and state or country): Chicago Ill.
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13a. FATHER'S NAME: Joseph Balczerowski
13b. MOTHER'S MAIDEN NAME: Josephine (Unknown)
14. NAME OF HUSBAND OR WIFE:
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) **********
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Miss Helen Boczek Address: 1514 Warren 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 cardio vascular dis. — INTERVAL BETWEEN ONSET AND DEATH: 5 yrs
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): cerebral sclerosis — 5 yrs
DUE TO (c): generalized infirmities — 2 to 3 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): 422.1
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 5/6/55 to 6/12/61 and last saw her/him alive on 6/12/61
Death occurred at 10 A.M. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): [illegible]
22b. ADDRESS: 1901 Madison St
22c. DATE SIGNED: 6/12/61

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 6/15/1961
23c. NAME OF CEMETERY OR CREMATORY: Calvary Cemetery
23d. LOCATION (City, town, or county) (State): St. Louis Mo.

24. FUNERAL DIRECTOR: JOHN STYGAR & SON — ADDRESS: 5541 RIVERVIEW BLVD.
25. DATE RECD. BY LOCAL REG.: JUN 12 1961
26. REGISTRAR'S SIGNATURE: Hoard 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 J M Rister

Licensed Embalmer No. 3980

P. O. Address St. Louis, Mo

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.