MISSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

8852 -61-034330
STATE FILE NUMBER

AMENDED

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

FILED OCT 13 1961

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: ST. LOUIS, MO.
Length of stay in 1b
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: ST. LOUIS CITY HOSP. #I
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): 2303 Howard St
Reside on Farm: Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First: JULIA (Juliania) Middle: Last: GALCZYNSKI
4. DATE OF DEATH: Month 9 Day 23 Year 61
5. SEX: Female
6. COLOR OR RACE: White
7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐
8. DATE OF BIRTH: 7/23/89
9. AGE (last birthday): 72
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): None
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: Joseph CYGANOWSKI
13b. MOTHER'S MAIDEN NAME: KATHERINE STELLER
14. NAME OF HUSBAND OR WIFE: BERNARD Deceased
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: Joseph Galczynski Address: 2305 Howard s

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): Acute Myocardial Infarction
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c): 4201
INTERVAL BETWEEN ONSET AND DEATH
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.)
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 8/2/61, to 9/23/61 and last saw her/him alive on 9/23/61
Death occurred at 2:00 AM m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: David L. Beals (Degree or title) M.D.
22b. ADDRESS: 1515 LAFAYETTE AVE.
22c. DATE SIGNED: 9/23/61

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE: 9/26/61
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
25. DATE RECD. BY LOCAL REG.: SEP 25 1961
26. REGISTRAR'S SIGNATURE: Earl Smith, M.D.

DATE AMENDED | INSTEAD OF | DOCUMENT | SHOULD READ | BY AFFIDAVIT OF | ITEM NO.

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. W. Rusta

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 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.