

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-034364

STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 8725

AMENDED

FILED SEP 27 1961

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>ILL.</u> b. COUNTY <u>Cook</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS</u>		Length of stay in 1b	c. CITY OR TOWN <u>CHICAGO</u>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ALEXIAN BROS. HOSP. D.O.A.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>1901 WEST 22ND. PL.</u>
		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>ALBERT</u> Middle <u>PAUL</u> Last <u>GORKA</u>	4. DATE OF DEATH Month <u>SEPT</u> Day <u>18</u> Year <u>1961</u>
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5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>1/30/37</u>	9. AGE (last birthday) <u>24</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HR Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Seminarian</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Roman Cath. Ch.</u>	11. BIRTHPLACE (City and state or country) <u>CHICAGO, ILL.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	

13a. FATHER'S NAME <u>Edward Gorka</u>	13b. MOTHER'S MAIDEN NAME <u>Mary Nehr</u>	14. NAME OF HUSBAND OR WIFE <u>none</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. <u>NONE</u>	17. INFORMANT <u>Father John Flynn</u>	Address <u>29000 Meramec</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		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Brain Injury; suffered in fall over</u>		
DUE TO (b) <u>Paralysis to floor below in building at</u>		
DUE TO (c) <u>2900 Meramec street, about 8:15 P.M. on Sept 16th 1961</u>		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH (e.g., chronic disease condition given in PART I (e)) <u>accident</u>	PART III. If deceased was female was there a pregnancy in last 90 days. <u>900.0-21</u> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input checked="" 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.) <u>See above</u>
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20c. TIME OF INJURY Hour <u>8:15</u> a.m. <u> </u> p.m. <u> </u> Month, Day, Year <u>9-16-61</u>
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20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>15 Home</u>	20f. CITY, TOWN, OR LOCATION <u>St. Louis, Mo</u>	COUNTY <u> </u>	STATE <u> </u>
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21. I attended the deceased from _____ to _____ and last saw her/him alive on _____
Death occurred at 8:30 P. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Helene L. Taylor</u>	(Degree or title) <u>Coroner</u>	22b. ADDRESS <u>1300 Clark Ave.</u>	22c. DATE SIGNED <u>9-19-61</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>9/20/61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Holy Sepulchre</u>	23d. LOCATION (City, town, or county) <u>Chicago Ill.</u>	(State) <u> </u>
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24. FUNERAL DIRECTOR <u>Schumacher's</u>	ADDRESS <u>3013 Meramec</u>	25. DATE RECD. BY LOCAL REG. <u>SEP 19 1961</u>	26. REGISTRAR'S SIGNATURE <u>Leon Smith, M.D.</u>
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MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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 Jack Haupt

Licensed Embalmer No. 4746

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.