

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-004706

J. Koller

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **517** STATE FILE NUMBER

AMENDED

FILED JAN 23 1962

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Ill</i> b. COUNTY <i>St Clair</i>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>St Louis</i>		Length of stay in lb <i>3 days</i>	c. CITY OR TOWN <i>East St Louis</i> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>Missouri Baptist Hosp</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <i>1401 Exchange</i> Residence on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <i>JOSEPH</i> Middle <i>WARZALA</i> Last			4. DATE OF DEATH Month <i>Jan</i> Day <i>11</i> Year <i>1962</i>		
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <i>9/25/1904</i>	9. AGE (last birthday) <i>57</i>	IF UNDER 1 YEAR Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Butcher</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Warzala Ink</i>		11. BIRTHPLACE (City and state or country) <i>East St Louis Ill</i>		12. CITIZEN OF WHAT COUNTRY <i>U.S.A</i>	
13a. FATHER'S NAME <i>Frank Warzala</i>			13b. MOTHER'S MAIDEN NAME <i>Veronica Kowalczyk</i>			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) <i>no</i>		16. SOCIAL SECURITY NO. <i>Unknown</i>		17. INFORMANT <i>Frank Warzala</i> Address <i>East St Louis Ill</i>	
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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) <i>Cardiac Venous thrombosis</i>			INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i> <i>2 days</i>
DUE TO (b) <i>Brain tumor</i>			
DUE TO (c) <i>491x</i>			

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		
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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 <i>8:30</i> a.m. p.m.		Month, Day, Year			
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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 *1/9/62* to *1/11/62* and last saw ^{her}him alive on *1/11/62*
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 <i>J. Koller</i> (Degree or title) <i>no</i>			22b. ADDRESS <i>2438 Work Rd No 8 units</i>			22c. DATE SIGNED <i>1/12/62</i>		
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23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>		23b. DATE <i>1/12/62</i>		23c. NAME OF CEMETERY OR CREMATORY <i>St. Adalbert</i>		23d. LOCATION (City, town, or county) <i>Center Township</i>		STATE <i>Ill</i>	
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24. FUNERAL DIRECTOR <i>John A. Gmach</i> ADDRESS <i>East St. Louis</i>			25. DATE RECD. BY LOCAL REG. JAN 12 1962		26. REGISTRAR'S SIGNATURE <i>Paul Smith M.D.</i>		
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DATE AMENDED
 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 SHOULD READ
 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 John A. Lynch

Licensed Embalmer No. 3398

P. O. Address _____

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.