

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-009160

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **1259**

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

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LEF FEB 19 1963

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY MISSOURI		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS		c. CITY OR TOWN ST. LOUIS	
Length of stay in 1b 60 YRS.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION ALEXIAN-BROTHERS		d. STREET ADDRESS (If outside, give location) 1633-HELEN-ST.	
Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ROSE (ROZALIA) NOWAK			4. DATE OF DEATH Month FEB. Day 4TH Year 1963
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 6-3-1885
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED-OFFICE-CLEANER		10b. KIND OF BUSINESS OR INDUSTRY JEFFERSON-HOTEL	11. BIRTHPLACE (City and state or country) AUSTRIA
13a. FATHER'S NAME JOSEPH-SZCZYGIEL		13b. MOTHER'S MAIDEN NAME ROZALIA-CIEPALA	14. NAME OF HUSBAND OR WIFE JOHN-NOWAK (DECD.)
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of serv) NO NONE		16. SOCIAL SECURITY NO.	17. INFORMANT Address ST. LOUIS WALTER-NOWAK= 4708-HATZ-AV. (20) MO.
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Congestive Heart Failure			INTERVAL BETWEEN ONSET AND DEATH 1 Day
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) arterio-sclerotic Cardio Vascular System			
DUE TO (c) 422.1			
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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
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.)	
20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year		
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
21. I attended the deceased from July 8 1961 to 2/4/63 and last saw her alive on 2/4/63 Death occurred at 3:30 P. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>[Signature]</i>		22b. ADDRESS 1401 Madison St	22c. DATE SIGNED 2/5/63
23a. BURIAL, CREMATION REMOVAL (Specify) BURIAL		23b. DATE FEB. 7TH 1963	23c. NAME OF CEMETERY OR CREMATORY CALVARY-CEMETERY
		23d. LOCATION (City, town, or county) ST. LOUIS	(State) MO.
24. FUNERAL DIRECTOR Brockland Und. Co. 1827-HOGAN-ST.		25. DATE RECD. BY LOCAL REG. FEB 6 1963	26. REGISTRAR'S SIGNATURE <i>[Signature]</i>

USE BLACK INK OR TYPEWRITER RIBBON

801 Fairfield
June 12 76 41

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 Flower Kahl

Licensed Embalmer No. 4596

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.