S. No. 2
M—2-43
. 5-17-39
I X35697

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

FILED MAY 16 1946

14209

State File No.

Registration District No. 310 Primary Registration District No. 3058 Registrar's No. 65

1. PLACE OF DEATH:

(a) County St Charles

(b) City or town St Charles
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St Joseph Hosp.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or ~~institution~~ 5 days (Specify whether
In this community
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Lincoln 57

(c) City or town Hawkpoint Mo
(If outside city or town limits, write "RURAL")

(d) Street No.
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME LUCY C STRANSKY

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex F

5. Color or race W

6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive years

7. Birth date of deceased Dec (Month) 13 (Day) 1894 (Year)

8. AGE: Years 51 Months 2 Days 20 If less than one day hr. min.

9. Birthplace Hawkpoint (City, town, or county) Missouri (State or foreign country)

10. Usual occupation Housework

11. Industry or business

FATHER
12. Name John Stransky
13. Birthplace Missouri (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Mary Martinek
15. Birthplace Missouri (City, town, or county) (State or foreign country)

16. (a) Informant Joe Stransky
(b) Address Hawkpoint Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-5-46 (Month) (Day) (Year)
(c) Place: burial or cremation Hawkpoint Catholic

18. (a) Signature of funeral director Wayne McCoy
(b) Address Troy Mo.

19. (a) April 8/46 (Date received local registrar) (b) Fannie Hamilton (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 3
year 1946 hour 9 minute 15 A M.

21. I hereby certify that I attended the deceased from
, 19, to , 19;
that I last saw her alive on March 3, 1946
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Pulmonary embolism	10 min
Due to Phlebitis of veins of the broad ligament	2 days
Due to Post operative uterine fibroid	5 days.
Other conditions (Include pregnancy within 3 months of death) Uterine fibroid	3 years

Major findings:
Of operations Uterine fibroid 1000 gms.
Of autopsy not done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
(Specify type of place)
While at work? (e) Means of injury

23. Signature B L Newberry (M. D. or other) Mo
Address St. Charles Mo Date signed 3/24/46

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(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 9,

District File Number.....

Date Filed 5-13-46

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.....

....., Registered Apprentice No.....,

working under my personal supervision.

Signed Wayne McCoy

Licensed Embalmer No. 3586

P. O. Address Troy 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 this body is not embalmed, fact should be so stated above.