

S. No. 2  
M-8-43  
7-5-17-39  
P-1 X37823

DEPARTMENT OF COMMERCE  
THE STATE BOARD OF HEALTH OF MISSOURI  
**FILED** MAY 20 1946  
STANDARD CERTIFICATE OF DEATH

State File No. **15616**

Registration District No. **5** Primary Registration District No. **5026 4014** Registrar's No. **13**

1. PLACE OF DEATH:  
(a) County **Aitchison**  
(b) City or town **Fairfax**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
In this community **11 yrs.** years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State **Missouri** (b) County **Aitchison**  
(c) City or town **Rural**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **7 Mi. S.W. of Fairfax Mo.**  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME **ANNA MISZAK**  
3. (b) If veteran, name war \_\_\_\_\_  
3. (c) Social Security No. \_\_\_\_\_

20. DATE OF DEATH: Month **APRIL** day **15**  
year **1946** hour **6** minute **40 P.** M.  
21. I hereby certify that I attended the deceased from **4-15**  
**7** 19**46** to **4-15** 19**46**  
that I last saw **or** alive on **4-15** 19**46**  
and that death occurred on the date and hour stated above.

4. **Female** 5. Color or race **white** 6. (a) **Single** divorced **Divorced**  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if  
alive \_\_\_\_\_ years  
7. Birth date of deceased: **September 29 1896**  
(Month) (Day) (Year)

Immediate cause of death **Chronic Myocarditis c. Myop-**  
**erocarditis** **Heart**  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_

8. AGE: Years **49** Months **6** Days **16** If less than one day  
hr. \_\_\_\_\_ min. \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death)  
Major findings: Of operations **93d**  
Of autopsy \_\_\_\_\_

9. Birthplace **Chicago Illinois**  
(City, town, or county) (State or foreign country)

10. Usual occupation **Wage-earner**

11. Industry or business **Name**

12. Name **Joseph Buleyok 4**

13. Birthplace **Unknown Germany**  
(City, town, or county) (State or foreign country)

14. Maiden name **Agnes Barnoski**

15. Birthplace **Unknown Germany**  
(City, town, or county) (State or foreign country)

(a) Informant **My Rose Perot**

(b) Address **Rt. 6 St. Joseph Mo.**

(c) Removal & Burial Date thereof **4/18/46**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(d) Place: burial or cremation **St. Olivet, St. Joseph**

(e) Signature of funeral director **Morain J. Schuster**

(f) Address **Fairfax, Missouri**

(g) **4-16-46** (h) **Miss H.D. Cunningham**  
(Date received local registrar) (Registrar's signature)

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?  
While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature **Marnie V. McDonald DO.**  
**Fairfax Mo.** Date signed **4-16-46**  
Address \_\_\_\_\_

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

OTHER FATHER

SON 1 4 1947

**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 Harwin W. Schaefer

Licensed Embalmer No. 4167

P. O. Address Tarifford, Missis.

**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.**