

No. 300
1-10-47
5-17-39
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FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

32114

State File No. _____

FILED NOV 1 1948

Registration District No. 42

Primary Registration District No. 1000

Registrar's No. 1141

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

1. PLACE OF DEATH:
 (a) County Buchanan
 (b) City or town St. Joseph, Mo
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: St. Joseph Hospital
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 1 Week
 42 Yrs. (Specify whether years, months or days)

3. (a) PRINT FULL NAME John W. Tworek
 3. (b) If veteran, name war no
 3. (c) Social Security No. none

4. Sex male
 5. Color or race white
 6. (a) Single, widowed, married, divorced, widowed
 6. (b) Name of husband or wife Mary deceased
 6. (c) Age of husband or wife if alive years
 7. Birth date of deceased March 1, 1882
(Month) (Day) (Year)

8. AGE: Years 66 Months 7 Days 222
If less than one day hr. min.

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

10. Usual occupation Retired CB&Q Employee

11. Industry or business Boiler washer, CB&Q

12. Name Walter Tworek

13. Birthplace Poland
(City, town, or county) (State or foreign country)

14. Maiden name Katherine
(City, town, or county) (State or foreign country)

15. Birthplace Poland
(City, town, or county) (State or foreign country)

16. (a) Informant Helen Ann Tworek Daughter

(b) Address 311 Ohio St. Joseph, Mo.

17. (a) Burial (b) Date thereof 10/26/48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Olivet Cemetery

18. (a) Signature of funeral director John H. Rupp
 (b) Address 6054 Pryor, St. Joseph, Mo.

19. (a) 10-28-48 (b) B. G. Jenkins
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Mo. (b) County Buchanan
 (c) City or town St. Joseph
(If outside city or town limits, write "RURAL")
 (d) Street No. 311 Ohio St.
(If rural, give location)
 (e) Citizen of foreign country? no (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 23
 year 1948 hour 5 minute 08 P.M.

21. I hereby certify that I attended the deceased from 9-27-48, 19 to 10-23-48, 19
 that I last saw him alive on 10-23-48, 19
 and that death occurred on the date and hour stated above.

Immediate cause of death PNEUMONIA Hypostatic
 Duration 14 days

Due to Heart Disease, Cor Pulmonale?

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: Of operations gsc
 Of autopsy _____

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? _____

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

23. Signature W. C. Jensen (M. D. or other)

Address 207 E. S. Blvd. Date signed 10-27-48

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.....

John C. Rupp
.....
Licensed Embalmer No. *3986*
P. O. Address: *St. Joseph, 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.