

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

273

State File No.

FILED JAN 25 1954

BIRTH NO. _____ REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 1000 Registrar's No. 53

1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Nebraska</u> b. COUNTY <u>Douglas</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Joseph</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Omaha</u>	
c. LENGTH OF STAY (If this place) <u>9 days</u>		d. STREET ADDRESS (If rural, give location) <u>5820 Glen Ave.</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Missouri Methodist Hospital</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>BERNARD</u> b. (Middle) _____ c. (Last) <u>KAMINSKI</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>January 12, 1954</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Oct. 18, 1917</u>
9. AGE (In years last birthday) <u>36</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck Driver</u>	11. BIRTHPLACE (State or foreign country) <u>Detroit, Michigan</u>
10a. USUAL OCCUPATION		10b. KIND OF BUSINESS OR INDUSTRY	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13a. FATHER'S NAME <u>Walter Kaminski</u>		13b. MOTHER'S MAIDEN NAME <u>Anna Harin</u>	14. NAME OF HUSBAND OR WIFE <u>Leona</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>507-09-8809</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Leona Kaminski</u> Nebr. ADDRESS <u>5820 Glen Ave., Omaha,</u>
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <u>MEDICAL CERTIFICATION</u>			INTERVAL BETWEEN ONSET AND DEATH <u>9 days</u>
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Second and third degree burns of 75% of the body</u>			
ANTECEDENT CAUSES *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death. Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>E 82 50 33</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>Accident</u>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>U.S. Highway # 36</u>	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>Near Sparks Doniphan 26 Kansas</u>
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>Jan. 3, 1954 P m.</u>		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>Was driver of stock truck which turned over and caught fire.</u>
22. I hereby certify that I attended the deceased from <u>Jan 3, 1954</u> , to <u>Jan 12, 1954</u> , that I last saw the deceased alive on <u>Jan 11, 1954</u> , and that death occurred at <u>7:40A m.</u> , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) <u>E. H. Butler M.D.</u>		23b. ADDRESS <u>902 Edmond St., City</u>	23c. DATE SIGNED <u>1-12-54</u>
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>Jan 12, 1954</u>	24c. NAME OF CEMETERY OR CREMATORY <u>St. Joseph</u>
24d. LOCATION (City, town, or county) (State) <u>Omaha, Nebr.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Wheaton Bowman</u> ADDRESS <u>St Joseph Mo.</u>	

DATE REC'D BY LOCAL REG. Jan 19, 1954 REGISTRAR'S SIGNATURE Beth M. Allison **485** FUNERAL DIRECTOR'S SIGNATURE Wheaton Bowman **485** ADDRESS St Joseph Mo.

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

4, 1, 1927

JAN 25 1927

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
Student Embalmer

Signed James P. Hawkins

Licensed Embalmer No. 4532

P. O. Address 319 E 10th St. J. J.

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.