

FILED APR 28 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **11357**Registrar's No. **253**BIRTH NO. _____ REG. DIST. NO. **43** PRIMARY REG. DIST. NO. **3007**

1. PLACE OF DEATH a. COUNTY Butler			2. USUAL RESIDENCE (Where deceased lived; if institution: residence before admission). a. STATE Missouri b. COUNTY Howell		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Poplar Bluff		c. LENGTH OF STAY (in this place) 16 Days	c. CITY OR TOWN Willow Springs		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION Veterans Administration Hospital			e. STREET ADDRESS (If rural, give location) Route 3		
3. NAME OF DECEASED (Type or Print) a. (First) FRANK b. (Middle) (NMI) c. (Last) SIKOWSKI			4. DATE OF DEATH (Month) (Day) (Year) April 17, 1954		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 11-20-98	9. AGE (In years) last birthday 55	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming	10b. KIND OF BUSINESS OR INDUSTRY Agriculture	11. BIRTHPLACE (City and State or Foreign Country) Chicago, Illinois		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME August Sikowski		13b. MOTHER'S MAIDEN NAME Pauline Hines		14. NAME OF HUSBAND OR WIFE Madeline Sikowski (Wife)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) Yes	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME ADDRESS VA HOSPITAL RECORDS, POPLAR BLUFF, MO.			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) CEREBRAL THROMBOSIS ANTECEDENT CAUSES GENERALIZED ARTERIOSCLEROSIS 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.				INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION 332 X				20. AUTOPSY? No YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) VA	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 4-1-54 , 19__ to 4-17-54 , 19__, XXXXXX and that death occurred at 11:20 am , from the causes and on the date stated above.					
23a. SIGNATURE Harry Price			23b. ADDRESS (Degree or title) Chief Medical Officer MO.		23c. DATE SIGNED 4-17-54
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 4-19-54	24c. NAME OF CEMETERY OR CREMATORY Willow Springs	24d. LOCATION (City, town, or county) (State) Willow Springs, Mo		
DATE REC'D BY LOCAL REG. 4/21/54	REGISTRAR'S SIGNATURE W. H. Minter	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Frank-Cotrell Poplar Bluff, Mo.			

(Licensed Embalmer's Statement on Reverse Side)

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

No. 300
10-48

RECEIVED

APR 26 1954

BUTLER CO. HEALTH CENTER

FILE No. _____

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 *Wallace R. Knight* _____

Licensed Embalmer No. *451*
4126

P. O. Address *poplar*
910

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (If 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.