

FILED SEP 26 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **29413**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **216** PRIMARY REG. DIST. NO. **3020** Registrar's No. **166**

1. PLACE OF DEATH a. COUNTY <i>Franklin</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <i>Missouri</i>	
b. CITY OR TOWN <i>Washington</i>		b. COUNTY <i>Franklin</i>	
c. LENGTH OF STAY (in this place) <i>7 weeks</i>		c. CITY OR TOWN <i>Washington</i>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <i>St. Francis Hospital</i>		d. Is Residence within limits of a city of incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
No. STREET ADDRESS <i>237 High</i>		(If rural, give location) <i>03620</i>	

3. NAME OF DECEASED (Type or Print) a. (First) <i>JOHN</i>	b. (Middle) <i>A.</i>	c. (Last) <i>CIERPIOT</i>	4. DATE OF DEATH (Month) (Day) (Year) <i>9 19 1955</i>
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5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <i>Widowed</i>	8. DATE OF BIRTH <i>3-27-1892</i>	9. AGE (In years last birthday) <i>63</i>	Months <i>5</i>	Days <i>22</i>	IF UNDER 14 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Labour</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Gas Work</i>	11. BIRTHPLACE (City and State or Foreign Country) <i>Krakow Missouri</i>	12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>
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13a. FATHER'S NAME <i>John Cierpiot</i>	13b. MOTHER'S MAIDEN NAME <i>Mary O'Flaherty</i>	14. NAME OF HUSBAND OR WIFE <i>Deceased</i>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, state war or dates of service) <i>No</i>	16. SOCIAL SECURITY NO. <i>498-05-4959</i>	17. INFORMANT'S SIGNATURE OR NAME <i>Mrs. Roland Kattelman</i>	ADDRESS <i>Washington, Mo.</i>
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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) <i>Metastatic Melanoma</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 yr.</i>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <i>Melanoma of head &amp; glands of neck 18 mos</i>		
	DUE TO (c) <i>None</i>		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <i>None</i>		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <i>Melanoma Sarcoma removed from head &amp; glands of neck 6-18-54</i>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from *6-18*, 1954, to *9-19*, 1955, that I last saw the deceased alive on *9-19*, 1955 and that death occurred at *11:30 p.m.*, from the causes and on the date stated above.

23a. SIGNATURE <i>L. M. Munch</i>	(Degree or title) <i>M.D.</i>	23b. ADDRESS <i>10th &amp; Washington Mo.</i>	23c. DATE SIGNED <i>9-20-55</i>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	24b. DATE <i>9-22-55</i>	24c. NAME OF CEMETERY OR CREMATORY <i>St. Francis Borgia Cemetery</i>	24d. LOCATION (City, town, or county) (State) <i>Washington Missouri</i>
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DATE REC'D BY LOCAL REG. <i>9/20/55</i>	REGISTRAR'S SIGNATURE <i>F. P. Schumann</i>	25. FUNERAL DIRECTOR'S SIGNATURE <i>W. &amp; Co. S. A. of</i>	ADDRESS <i>Mo. Willibronk</i>
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(Licensed Embalmer's Statement on Reverse Side)

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

OCT 27 1958

OCT 17 1958

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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 *J. W. Willenbrink*

Licensed Embalmer No. *4511*

P. O. Address *Washington, D.C.*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.