

THE DIVISION OF HEALTH OF MISSOURI  
**STANDARD CERTIFICATE OF DEATH**

39245  
STATE FILE NUMBER

FILED DEC 9 - 1957

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 1308

V. S. 300  
Rev. 1-57

1. PLACE OF DEATH a. COUNTY <b>Buchanan</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Buchanan</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Joseph</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>St. Joseph</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Joseph's Hosp.</b>		Length of stay in 1b <b>33yrs</b>	d. STREET ADDRESS (If outside, give location) <b>1517 Dewey Avenue</b>		Reside on Form Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>LEO</b>			4. DATE OF DEATH Month <b>Nov.</b> Day <b>23</b> Year <b>1957</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 30, 1882</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Butcher</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Armour &amp; Co.</b>	11. BIRTHPLACE (City and state or country) <b>Germany</b>		
13a. FATHER'S NAME <b>Paul Czerwonke</b>		13b. MOTHER'S MAIDEN NAME <b>- Machalafska</b>	14. NAME OF HUSBAND OR WIFE <b>Mrs. Martha Czerwonke</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>487-09-1093</b>	17. INFORMANT Address <b>Mrs. Martha Czerwonka St. Joseph, Mo.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebrovascular Accident</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Hypertensive &amp; arteriosclerotic</b> DUE TO (c) <b>Cardiovascular Disease</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>443X</b>					INTERVAL BETWEEN ONSET AND DEATH <b>12 hours</b> <b>years</b>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I (a) or PART II of item 18.)		
20c. TIME OF INJURY Hour _____ Month, Day, Year _____ a.m. _____ p.m. _____					
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE		
21. I attended the deceased from <u>11/23/57</u> to <u>11/23/57</u> and last saw <sup>her</sup> <sub>him</sub> alive on <u>11/23/57</u> Death occurred at <u>4:00P</u> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <b>Donald J. Stotland, M.D.</b> (Degree or title)			22b. ADDRESS <b>902 E. Diamond</b>		22c. DATE SIGNED <b>11/25/57</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>11-26-57</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>St. Joseph Missouri</b>	
24. FUNERAL DIRECTOR ADDRESS <b>Stacey Funeral Home St. Joseph, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>Dec. 4, 1957</b>	26. REGISTRAR'S SIGNATURE <b>Mrs. Robert Fulton</b>		

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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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 *George A. Kerby*.....

Licensed Embalmer No. *4752*.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting. If this body is not embalmed, fact should be so stated above.