

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-005809

STATE FILE NUMBER 1012

REGISTRATION DISTRICT NO. 149 PRIMARY REGISTRATION DISTRICT NO. 1.002 REGISTRAR'S NO.

1. PLACE OF DEATH
a. COUNTY JACKSON

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MISSOURI b. COUNTY JACKSON

b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KANSAS CITY Inside Limits Yes No
c. CITY OR TOWN 207 Askew Kansas City Inside Limits Yes No

c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 207 Askew Length of stay in hospital 8 1/2 yrs d. STREET ADDRESS (If outside, give location) 207 Askew Reside on Farm Yes No

3. NAME OF DECEASED First Middle Last BORIS POSLAWSKI 4. DATE OF DEATH Month Day Year Feb 21, 1959

5. SEX male 6. COLOR OR RACE white 7. MARRIED NEVER MARRIED WIDOWED DIVORCED 8. DATE OF BIRTH Aug 6, 1897 9. AGE (In years last birthday) 61 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Custodian 10b. KIND OF BUSINESS OR INDUSTRY Steel Co 11. BIRTHPLACE (City and state or country) Russia 12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME Eugene Poslowski 13b. MOTHER'S MAIDEN NAME Maria Sulima 14. NAME OF HUSBAND OR WIFE Olga Poslowski

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no 16. SOCIAL SECURITY NO. 497-34-7387 17. INFORMANT Mrs Zoya Bucko 207 Askew K.C. Mo Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Occlusion
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____
DUE TO (c) _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) _____
INTERVAL BETWEEN ONSET AND DEATH _____

19. WAS AUTOPSY PERFORMED? YES NO

20a. ACCIDENT SUICIDE HOMICIDE 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.

20d. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 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 Jan 26, 1959 to Feb. 21, 1959 and last saw her alive on 2-21-59
Death occurred at 3 PM m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Don A. Black MD 22b. ADDRESS Prof. Bldg. K.C. Mo 22c. DATE SIGNED 2/23/59

23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL 23b. DATE 2/24/59 23c. NAME OF CEMETERY OR CREMATORY Highland Park Cemetery 23d. LOCATION (City, town, or county) (State) K.C. Ks.

24. FUNERAL DIRECTOR ADDRESS JOS A. BUTLER'S SONS K.C. K 25. DATE RECD. BY LOCAL REG. 2-23-59 26. REGISTRAR'S SIGNATURE neva Marshall

(Licensed Embalmer's Statement on Reverse Side)

Health, Welfare Public Service

300 1-57

vector, coroner, etc.; must use only standard nomenclature in their reports. No symptoms with reference to all diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION
Don A. Black

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 *Ralph O. Gruhl*

Licensed Embalmer No. *5004*

P. O. Address *R. C. Kan*

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.