

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-000340

FILED VS JAN 18 1960

042

Primary Registration District No. 1000

Registrar's No. 49

STATE FILE NUMBER

DEED

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY Buchanan	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph		c. CITY OR TOWN St. Joseph	
Length of stay in 1b 48 yrs		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 417 Ohio		d. STREET ADDRESS (If outside, give location) 417 Ohio	
Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Joseph Middle F Last Kaczak			4. DATE OF DEATH Month Jan Day 10 Year 1960
5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH June 21, 1911
9. AGE (last birthday) 48		IF UNDER 1 YEAR Months 48	IF UNDER 24 HR Days 48 Hours 48 Min. 48
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Butcher		10b. KIND OF BUSINESS OR INDUSTRY Swift & Co	11. BIRTHPLACE (City and state or country) St. Joseph, Mo
12. CITIZEN OF WHAT COUNTRY U.S.A.		13a. FATHER'S NAME Michael Kaczak	
13b. MOTHER'S MAIDEN NAME Catherine Kaczak		14. NAME OF HUSBAND OR WIFE none	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war, or dates of service) Yes W.W. #11		16. SOCIAL SECURITY NO. 495-07-1200	
17. INFORMANT Sophia Gabbert		Address St. Joseph, Mo	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of tongue & extension to two cervical glands and neck DUE TO (b) to two cervical glands and neck DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH approx 5 mo
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	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 or PART II of item 18.)	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE 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 3-22-55 to 1-10-60 and last saw him alive on 11-12-59 Death occurred at 1:30 P.M. m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Wm B. Roehm D		22b. ADDRESS 316 W 10th St Joseph Mo	
22c. DATE SIGNED 1-11-60		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
23b. DATE 1/13/60		23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery	
23d. LOCATION (City, town or county) (State) St. Joseph, Mo		24. FUNERAL DIRECTOR ADDRESS St. Joseph, Mo	
25. DATE RECD. BY LOCAL REG. Jan 14, 1960		26. REGISTRAR'S SIGNATURE Mrs. Clark Standell	

DOCUMENT

BY AFFIDAVIT OF **Wm B. Roehm D** MEDICAL CERTIFICATION

