

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

3932 -61-029216
STATE FILE NUMBER

AMENDED Registration District No. 149 Primary Registration District No. 1002 Registrar's No. _____

FILED AUG 28 1961

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|---|---------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>JACKSON</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MONTANA</u> COUNTY <u>ANACONDA</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>KANSAS CITY</u> | | Length of stay in 1b <u>4 DAYS</u> | c. CITY OR TOWN <u>ANACONDA</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>HOTEL NEW YORKER</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) <u>UNK.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First <u>JOSEPH</u> Middle <u>F</u> Last <u>DOMITROVICH</u> | | | 4. DATE OF DEATH Month <u>8</u> Day <u>7</u> Year <u>61</u> |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>MAR 3 1906</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PIPE FITTER</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>ANACONDA CO</u> | 9. AGE (last birthday) <u>61</u> IF UNDER 1 YEAR Months Days IF UNDER 24 HR Hours Min. |
| 11. BIRTHPLACE (City and state or country) <u>ANACONDA, MONT</u> | | 12. CITIZEN OF WHAT COUNTRY | |
| 13a. FATHER'S NAME <u>ANTONE DOMITROVICH</u> | | 13b. MOTHER'S MAIDEN NAME <u>MARY EVANATIC</u> | 14. NAME OF HUSBAND OR WIFE <u>EVELYN</u> |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 17. INFORMANT Address <u>EVELYN DOMITROVICH SAME</u> | |

| | | |
|---|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> | | INTERVAL BETWEEN ONSET AND DEATH |
| 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) | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input 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 _____, to _____ and last saw her/him alive on _____
Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.

| | | |
|--|---|--|
| 22a. SIGNATURE (Degree or title) <u>Ruth H. Owens</u> | 22b. ADDRESS <u>152 Union Station</u> | 22c. DATE SIGNED <u>8-7-61</u> |
| 23a. BURIAL, CREATION, REMOVAL (Specify) <u>REMOVAL</u> | 23b. DATE <u>8-9-61</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>MT OLIVET CEM</u> |
| 24. FUNERAL DIRECTOR, ADDRESS <u>SEBBETOS K.C. Mo.</u> | 25. DATE RECD. BY LOCAL REG. <u>8-8-61</u> | 26. REGISTRAR'S SIGNATURE <u>Ruth Long</u> |

DATE AMENDED
 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 BY AFFIDAVIT OF
 High H. Owens
 ITEM NO. SHOULD READ

JUN 8 1966

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 Forrest D. Coldman

Licensed Embalmer No. 4714

P. O. Address RC 200

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.