

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-031302

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 4227

FILED SEP 4 1962

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF
George K. Boyd

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY Jackson		a. STATE Kansas b. COUNTY Wyandotte	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		c. CITY OR TOWN Kansas City	
Length of stay in lb 5 days		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St Josephs Hospital		d. STREET ADDRESS (If outside, give location) 61 South 8th St.	
Inside Limits 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)		4. DATE OF DEATH	
First WALTER Middle J. Last SKIBNIEWSKI (SKIBINSKI)		Month August Day 14 Year 1962	
5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH May 6, 1888
9. AGE (last birthday) 74		IF UNDER 1 YEAR Months 74 Days	IF UNDER 24 HR Hours 74 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Sausage		10b. KIND OF BUSINESS OR INDUSTRY Swift & Co.	11. BIRTHPLACE (City and state or country) Poland
12. CITIZEN OF WHAT COUNTRY US		13a. FATHER'S NAME Joseph Skibniewski	
13b. MOTHER'S MAIDEN NAME Mary Dovner		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 serv) No		16. SOCIAL SECURITY NO. [REDACTED]	
17. INFORMANT Mrs Sophie Splechter		Address 61 S. 8th KCK	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY:			INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) Respiratory Failure			30 min
DUE TO (b) Profound Cerebral Ischemia			6 months
DUE TO (c) Cerebral Arteriosclerosis			3 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Generalized Arteriosclerosis			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 6:30 a.m. p.m.	Month, Day, Year May 1, 62	20f. CITY, TOWN, OR LOCATION present	
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. COUNTY Kansas STATE Kansas	
21. I attended the deceased from May 1, 62 to present and last saw him alive on 8-14-62		Death occurred at 6:30 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE George K Boyd MD (Degree or title)		22b. ADDRESS 511 Independence Ave.	22c. DATE SIGNED 8-15-62
23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE Aug. 17, 1962	23c. NAME OF CEMETERY OR CREMATORY Mt. Calvary	23d. LOCATION (City, town, or county) (State) Kansas City, Kansas
24. FUNERAL DIRECTOR Jos. A. Butler's Son's ADDRESS Kansas City, Kan.		25. DATE RECD. BY LOCAL REG. 8-15-62	26. REGISTRAR'S SIGNATURE Ruth Long

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 Russell W Dennis

Licensed Embalmer No. 3462 (mo)

P. O. Address Kansas City, Kansas

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.