

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

**-62-045953**  
STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 1424

<b>FILED DEC 26 1962</b>	
1. PLACE OF DEATH a. COUNTY <b>Buchanan</b>	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo</b> b. COUNTY <b>Buchanan</b>
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Joseph</b>	Length of stay in lb <b>52yrs</b>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Joseph Hospital</b>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. STREET ADDRESS (If outside, give location) <b>210 Michigan</b>	
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Morris</b> Middle <b>A</b> Last <b>Filkovich</b>	
4. DATE OF DEATH Month <b>Dec</b> Day <b>13</b> , Year <b>1962</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>Dec 27, 1894</b>
9. AGE (last birthday) <b>67</b>	
IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>	
IF UNDER 24 HR Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Baker</b>	
10b. KIND OF BUSINESS OR INDUSTRY <b>Bakery</b>	
11. BIRTHPLACE (City and state or country) <b>Yugoslavia</b>	
12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>Ignatus Filkovich</b>	
13b. MOTHER'S MAIDEN NAME <b>Amanda Berkovich</b>	
14. NAME OF HUSBAND OR WIFE <b>Daisy Filkovich</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. [Blank]	
17. INFORMANT Address <b>Daisy Filkovich, St. Joseph, Mo</b>	
18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart Failure</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	
DUE TO (b) <b>Anemia</b>	
DUE TO (c) <b>Carcinoma of colon</b>	
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 <b>2/9/54</b> , to <b>12/13/62</b> and last saw her/him alive on <b>12/13/62</b> Death occurred at <b>10:39 A.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE (Degree or title) <b>Sharon E. Waggoner M.D.</b>	
22b. ADDRESS <b>301 Illinois Ave St. Joseph, Missouri</b>	
22c. DATE SIGNED <b>12/14/62</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>12/15/62</b>
23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>	
23d. LOCATION (City, town, or county) (State) <b>St. Joseph, Mo</b>	
24. FUNERAL DIRECTOR ADDRESS <b>St. Joseph, Mo</b>	
25. DATE RECD. BY LOCAL REG. <b>Dec. 19, 1962</b>	
26. REGISTRAR'S SIGNATURE <b>Mrs. Clark Goodell</b>	

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DATE AMENDED  
INSTEAD OF  
SHOULD READ  
BY AFFIDAVIT OF

DOCUMENT

S. E. Waggoner, M.D. CERTIFICATION

USE BLACK INK OR TYPEWRITER RIBBON

JAN 16 1963

Permitted 12/19/62

**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,

\_\_\_\_\_ Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Joseph Rupp

Licensed Embalmer No. 3986

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.