

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH.

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-020220

2861

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 2861

FILED JUN 3 1963

VS-300. Rev. 4/59	AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF DOCUMENT MEDICAL CERTIFICATION BY AFFIDAVIT OF	DATE AMENDED
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ITEM NO.	SHOULD READ	

1. PLACE OF DEATH a. COUNTY JACKSON		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE KANSAS b. COUNTY WYANDOTTE	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KANSAS CITY, MISSOURI		Length of stay in 1b 5 weeks	c. CITY OR TOWN KANSAS CITY, KANSAS. Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION VA HOSPITAL, KC, MO.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 524 OHIO Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First MARIE Middle ANNA Last MIKULIC		4. DATE OF DEATH Month MAY Day 18, Year 1963	
5. SEX FEMALE	6. COLOR OR RACE white	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 8/13/24
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK TYPIST		10b. KIND OF BUSINESS OR INDUSTRY CLERICAL	11. BIRTHPLACE (City and state or country) AKRON, OHIO
13a. FATHER'S NAME CARL GUNDILACH		13b. MOTHER'S MAIDEN NAME THERESA RUIZ	14. NAME OF HUSBAND OR WIFE John F. Mikulic
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES 12/9/51 to 2/8/54		16. SOCIAL SECURITY NO.	
17. INFORMANT VA HOSP RECORDS Address 524 Ohio		17. INFORMANT John F. Mikulic (Husband) Kc, Kan.	
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 THE PANCREAS WITH CARCINOMATOSIS			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 Her	COUNTY _____ STATE _____
21. I attended the deceased from 4/12/63 to 5/18/63 and last saw him alive on 5/18/63 Death occurred at 3:00 AM 5/18/63 m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Robert Laing MD		22b. ADDRESS VA HOSPITAL, KANSAS CITY, MO	22c. DATE SIGNED 5-18-63
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	23b. DATE 5-18-63	23c. NAME OF CEMETERY OR CREMATORY Mt. CALVARY - CEM.	23d. LOCATION (City, town, or county) K.C. KANS.
24. FUNERAL DIRECTOR SKRADSKY - FUNERAL HOME K.C. MO.		25. DATE RECD. BY LOCAL REG. 5-18-63	26. REGISTRAR'S SIGNATURE Ruth Long

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1935

STATE OF MISSOURI
DEPARTMENT OF HEALTH

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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 W. Leroy Mooney

Licensed Embalmer No. 4726

P. O. Address K. C. 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.