

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-025483

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 310 Primary Registration District No. 6051 Registrar's No. 37a

FILED JUL 15 1963

VS 300  
Rev. 4/59

10920

20928

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1350

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY <b>ST. CHARLES</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MO.</b> b. COUNTY <b>ST. CHARLES</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>ST. CHARLES TWP</b>		Length of stay in 1b <b>TRANSIT</b>	c. CITY OR TOWN <b>ST. CHARLES</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>HWY. 94, 8 MI. WEST OF CHARLES ST.</b>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>2302 CHARBO</b>		
3. NAME OF DECEASED (Type or print) First <b>MICHAEL</b> Middle <b>ANTHONY</b> Last <b>CZARNECKY</b>			4. DATE OF DEATH Month <b>JULY</b> Day <b>7</b> Year <b>1963</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>8 FEB. 1946</b>	9. AGE (last birthday) <b>17</b> IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HR: Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>SHEET METAL</b>		11. BIRTHPLACE (City and state or country) <b>ST. LOUIS, MO.</b>	12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13a. FATHER'S NAME <b>WILBUR E. CZARNECKY</b>			13b. MOTHER'S MAIDEN NAME <b>LUCILLE KULIK</b>		14. NAME OF HUSBAND OR WIFE <b>NONE</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>			17. INFORMANT Address <b>3 WILBUR E. CZARNECKY, ST. CHARLES, MO.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:					INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <b>BROKEN NECK</b>					<b>INSTANT</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>CRUSHED CHEST</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 checked="" 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.) <b>AUTO ACCIDENT</b>				
20c. TIME OF INJURY Hour <b>6:40</b> a.m. Month, Day, Year <b>July 7, 1963</b>	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>HWY. 94, 8 MI. WEST OF CHARLES ST.</b>	20f. CITY, TOWN, OR LOCATION <b>ST. CHARLES TWP.</b>	COUNTY <b>ST. CHARLES</b>	STATE <b>MO.</b>	
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at <b>6:40</b> _____ a.m. on the date stated above, and to the best of my knowledge, from the causes stated.						
21a. SIGNATURE (Degree or title) <b>Justin Blankenship, Acting Coroner</b>			22b. ADDRESS <b>120 So. Second St. St. Charles, Mo.</b>		22c. DATE SIGNED <b>7-7-1963</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>	23b. DATE <b>10 JULY 1963</b>	23c. NAME OF CEMETERY OR CREMATORY <b>CALVARY CEMETERY</b>	23d. LOCATION (City, town, or county) <b>ST. LOUIS</b>	STATE <b>MO.</b>		
24. FUNERAL DIRECTOR <b>PRINSTER-BAUE F.H. ST. CHARLES, MO.</b>			ADDRESS <b>July 10 - 1963</b>	25. DATE RECD. BY LOCAL REG. <b>July 10 - 1963</b>	26. REGISTRAR'S SIGNATURE <b>Mabel Sulmawalt</b>	

JUL 18 1968

**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

*Frederic H. Paine*

Licensed Embalmer No.

4607

P. O. Address

St. Charles, 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.