

26 1928

3.2

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

36143

1. PLACE OF DEATH

County Berks
Township St. Joseph
City St. Joseph

Registration District No. 85
Primary Registration District No. 1001

File No. _____
Registered No. 1306
St. _____ Ward _____

2. FULL NAME

Joseph Zawada
(a) Residence. No. State Hosp #2 St. _____
(Usual place of abode)

Length of residence in city or town where death occurred 17 yrs. mos. da. How long in U.S., if of foreign birth? 17 yrs. mos. da. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

5A. If MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF (Married) R. Oose

6. DATE OF BIRTH (MONTH, DAY AND YEAR) March 18, 1881

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
47 8 0

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employee)
(c) Name of employer Austria Poland

9. BIRTHPLACE (CITY OR TOWN) Unknown
(STATE OR COUNTRY) Poland

10. NAME OF FATHER Albert Zawada

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Unknown
(STATE OR COUNTRY) Poland

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Unknown
(STATE OR COUNTRY) Unknown

14. INFORMANT Judge J. Sampson
(address) St. Joseph, Mo.

15. FILED 19 1928
REGISTRAR [Signature]

MEDICAL CERTIFICATE OF DEATH

15. DATE OF DEATH (MONTH, DAY AND YEAR) 11-18- 1928

17. I HEREBY CERTIFY That I attended deceased from April 1, 1928 to Nov. 18, 1928
that I last saw him alive on Nov 18, 1928, and that death occurred, on the date stated above, at 11:30 A.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pulmonary Tuberculosis
32 yrs. (duration) yrs. mos. da.

CONTRIBUTORY (SECONDARY) 31
(duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? No. DATE OF _____
WAS THERE AN AUTOPSY? No.

WHAT TEST CONFIRMED DIAGNOSIS? Clinical
(Signed) J. R. Burch, M. D.
11/18/1928 (Address) State Hosp #2

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Mt. Olivet Cemetery DATE OF BURIAL Nov. 20 1928

20. UNDERTAKER H. W. Sinden ADDRESS 1802 Union St.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

PERMANENT RECORD

