

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

Do not use this space.

36142

1. PLACE OF DEATH

County Jackson
Township York
City Kansas Grove (No. 902)

Registration District No. 399
Primary Registration District No. 1002

File No. _____
Registered No. 4547 (Ward _____)

2. FULL NAME

(a) Residence No. 902 Winchester St. 12 Ward. _____

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

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Male</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Single</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>unk 1893</u>		
7. AGE YEARS <u>About 37</u>	MONTHS _____	DAYS _____
8. OCCUPATION OF DECEASED <u>Operating Machine in Wire Mill</u> (a) Trade, profession, or particular kind of work <u>Shuffield Steel Co.</u> (b) General nature of industry, business, or establishment in which employed (or employer) _____ (c) Name of employer _____		

9. BIRTHPLACE (CITY OR TOWN) Pratica
(STATE OR COUNTRY) Europe

PARENTS	10. NAME OF FATHER <u>unknown</u>
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) <u>unknown</u>
	12. MAIDEN NAME OF MOTHER <u>unknown</u>
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) <u>unknown</u>

14. INFORMANT Mike Kovacsich
(Address) 1637 Madison

15. FILED 11/9/30 M. M. Conroy REGISTRAR
Asst

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 11-7 1930

17. I HEREBY CERTIFY That I attended deceased from _____, 19____, to _____, 19____, that I last saw him alive on _____, 19____, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Homicide Stab wound
174 (duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY) 198 (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED _____

IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? Yes DATE OF _____

WAS THERE AN AUTOPSY? Yes

WHAT TEST CONFIRMED DIAGNOSIS Autopsy
(Signed) Stanley M. Hall, M. D.
11-8, 1930 (Address) Happy Corner

*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 M. Calvary DATE OF BURIAL 11-10 1930

20. UNDERTAKER Skraski & Son ADDRESS K.C. K.

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.

