

REC'D JUN 14 1939

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

18127
Do not use this space.

1. PLACE OF DEATH

(a) County Buchanan Registration District No. 85
(b) Township Washington Primary Registration District No. 1001
(c) or City St. Joseph. (d) Street No. St. Joseph's Hospital St.
(e) Length of residence in city or town where death occurred 27 yrs. mos. ds. (f) How long in U.S., if of foreign birth? 27 yrs. mos. ds.
(If death occurred in Hospital or Institution, write its name instead of street and number)

2. PRINT FULL NAME

William Homik.
(a) Residence, No. 508 Virginia St. (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

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 Mabel Homik.

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Dec. 15, 1893.

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
45 5 23

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Beef Butcher.
9. Industry or business in which work was done, as saw mill, bank, etc. Armour & Co.
10. Date deceased last worked at this occupation (month and year) May 28, 1939. 11. Total time (years) spent in this occupation 25 Yrs.

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

FATHER 13. NAME Unknown.

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown. Unknown.

MOTHER 15. MAIDEN NAME Unknown.

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown. Unknown.

17. INFORMANT (ADDRESS) Mrs Mabel Homick. 508 Virginia.

18. BURIAL, CREMATION, OR REMOVAL PLACE Mt. Auburn Cem. St. Joseph Mo. DATE June 10, 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) H.O. Sidenfaden & Son 1802 Union St. St. Joseph Mo.

20. FILED 6-9 39 A. H. Nettles Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) June 8, 1939

22. I HEREBY CERTIFY, That I attended deceased from June 7, 1939, to June 8, 1939.
I last saw him alive on June 8, 1939. Death is said to have occurred on the date stated above, at 2 A.M.
The principal cause of death and related causes of importance were as follows:

Myelogenous Leukemia Date of onset unknown
Other contributory causes of importance: None

Name of operation ✓ Date of ✓
What test confirmed diagnosis? Clinical Was there an autopsy? Yes

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? ✓ Date of injury ✓, 1939
Where did injury occur? ✓ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury ✓
Nature of injury ✓

24. Was disease or injury in any way related to occupation of deceased? No
If so, specify ✓
(Signed) Gustav H. Linn, M. D.
(Address) 1117 North Patrick Blvd. St. Joseph, Mo.

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.

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JAN 9 1942

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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.....

Robert P. Clarkson....., Registered Apprentice No.....
working under my personal supervision.

Signed Robert P. Clarkson

Licensed Embalmer No. 4028

P. O. Address 1802 Union

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 this body is not embalmed, above space should be left blank.