

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

1373

State File No. _____

358

Registrar's No. _____

Registration District No. 399

Primary Registration District No. 1002

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St. Mary's Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 6 days
(Specify whether years, months or days)

In this community 54 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Kansas (b) County _____

(c) City or town Kansas City
(If outside city or town limits, write "RURAL")

(d) Street No. 1850 N. 27th St.
(If rural, give location)

(e) If foreign born, how long in U. S. A. 54 years years.

3. (a) PRINT FULL NAME Carl Bartkowski

3. (b) If veteran, name war No

3. (c) Social Security No. No

4. Sex Male

5. Color or race Wh

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Mary Bartkowski

6. (c) Age of husband or wife if alive 1861 years

7. Birth date of deceased Feb. 6
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>78</u>	<u>11</u>	<u>17</u>	hr. _____ min. _____

9. Birthplace Warsaw Poland
(City, town, or county) (State or foreign country)

10. Usual occupation Retired Employee

11. Industry or business Swift & Co.

MOTHER FATHER

12. Name Unknown

13. Birthplace Poland
(City, town, or county) (State or foreign country)

14. Maiden name UNKNOWN

15. Birthplace Poland
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mrs. Anna Dickey

(b) Address 4022 Warwick

17. (a) Burial (b) Date thereof 1-25-48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Maple Hill-RCK

18. (a) Signature of funeral director J. W. Wagner

(b) Address Kansas City, Mo.

19. (a) Jan. 25, 1940 (b) M. M. Brown
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 23rd
year 1940 hour 4 minute 05 P. M.

21. I hereby certify that I attended the deceased from 1/18
1940 to 1-23 1940
that I last saw h. alive on 1/23 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Bronchial Pneumonia 1 wk
Right side Heart Failure 3 days
Chronic arterio-sclerotic heart disease

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____

Of autopsy _____

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place)

(e) Means of injury _____

23. Signature H. C. Connell M.D. (M. D. or other) _____
Address 810 Medical Arts Bldg Date signed 1/24/40

ME 3564
Med Ante

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 _____
_____, Registered Apprentice No. _____
working under my personal supervision.

Signed Cecil P. Matthews

Licensed Embalmer No. 3807

P. O. Address H. C. MD

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.