

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.

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

13719

State File No. \_\_\_\_\_

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. 1431

1. PLACE OF DEATH:

(a) County Jackson  
(b) City or town Kansas City  
(c) Name of hospital or institution:  
5331 Highland  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 9 years 6 month  
(Specify whether  
In this community  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson  
(c) City or town Kansas City  
(If outside city or town limits, write "RURAL")  
(d) Street No. 5331 Highland  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 31  
year 1940 hour 9 minute 30 a. M.  
21. I hereby certify that I attended the deceased from Oct 8  
1938, 19   to March 31, 1940  
that I last saw her alive on March 31, 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death  
Chronic Myocarditis  
Duration 18  
months

Due to Chronic Sclerosis  
Due to 93. C's

Other conditions  
(Include pregnancy within 3 months of death)

PHYSICIAN  
Major findings:  
Of operations \_\_\_\_\_  
Of autopsy no  
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 \_\_\_\_\_  
28. Signature Paul J. P. Ruske (M. D. or other) MD  
Address 1402 Bryant Bldg Date signed 4/1/40

3. (a) PRINT FULL NAME AGNES MULESKI 4' 3"  
3. (b) If veteran, name war No 3. (c) Social Security No. None

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced, widowed

6. (b) Name of husband or wife Frank Peter Muleski 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased December Unk 1883  
(Month) (Day) (Year)

8. AGE: Years 76 Months 3 Days 0 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation None

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Simon Stevens

18. Birthplace Germany  
(City, town, or county) (State or foreign country)

14. Maiden name Mary

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

16. (a) Informant's own signature Frank S. Muleski

(b) Address North Kansas City Mo

17. (a) Burial (b) Date thereof 4/2/40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Olivet Cem.  
St. Joseph Mo

18. (a) Signature of funeral director Swick & Tobin Co  
(b) Address Kansas City, Mo

19. (a) April 1, 1940 (b) M. M. Osborne  
(Date received local registrar) (Registrar's signature)

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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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed *Maurice Buis*

Licensed Embalmer No. *3694*

P. O. Address.....

**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.**