

No. 2
11-10-39
5-17-39
1 X21492

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

38653

State File No.

Registration District No.

Primary Registration District No.

Registrar's No.

1. PLACE OF DEATH:

- (a) County Franklin
(b) City or town Union
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether
In this community years, months or days)

3. (a) PRINT FULL NAME Frank A. Wozniak (Warnick)

3. (b) If veteran,
name war

3. (c) Social Security
No. 498-05-9370

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

6. (b) Name of husband or wife Gertrude 6. (c) Age of husband or wife if
alive years

7. Birth date of deceased Nov. 26, 1891
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
49 11 13 hr. min.

9. Birthplace St. Louis, Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Electric Mechanic

11. Industry or business

12. Name Michael Wozniak

13. Birthplace U.S.A.
(City, town, or county) (State or foreign country)

14. Maiden name Julia Jesse

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

16. (a) Informant Mrs. Gertrude Wozniak (Warnick)

(b) Address Union, Missouri

17. (a) Burial (b) Date thereof 11/12/40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation I.C.C. Cemetery

18. (a) Signature of funeral director Wm. H. How

(b) Address Union, Mo.

19. (a) 11-12-40 (b) Louis F. Hankins
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Franklin

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

(d) Street No. (If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 9th
year 1940 hour 10 minute 40 P.m.

21. I hereby certify that I attended the deceased from 8/28
11/9 to 11/9, 1940
that I last saw him alive on 11/9
and that death occurred on the date and hour stated above.

Immediate cause of death Circulatory Collapse Duration 8 hrs.

Due to Recurrent Brain
tumor (metastatic)
Due to Carcinomatosis 1 1/2 yrs

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations Metastatic Brain
tumor Sept 12 - 1939
Of autopsy

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?
854

While at work? (Specify type of place) (e) Manner of injury

23. Signature Michael S. McNeill (M.D. or other)
Address Union, Mo. Date signed 11/11/40

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

Weyl H. Home

Licensed Embalmer No. *3175*

P. O. Address *Union, Mo.*

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.