

FILLED JUN 10 1941 MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

17407 41

File No. 2069

Registered No. St. Ward

1. PLACE OF DEATH

County Jackson Registration District No. 399
Township Kaw Primary Registration District No. 1092
City Kansas City (No. Lafayette Hospital)

2. FULL NAME

Valeria Bastka
(a) Residence, No. 7014 E. 12th Terrace St. Ward. (If nonresident, give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE Wh 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) single (1)
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OR S. S. #487-09-9097
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Nov-5-1908
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 32 6 21

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. machine operator
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. for Donnelly's garment 300
10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Oklahoma 1

13. NAME Adam Bastka

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Russia 6

15. MAIDEN NAME Frances Sphiriski

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Poland 4

17. INFORMANT (ADDRESS) Lillian Bastka 7014 E. 12th Terrace

18. BURIAL, CREMATION, OR REMOVAL PLACE St Marys Cemetery 5 8 44

19. UNDERTAKER (ADDRESS) F. J. Walter 2738 Prospect

20. FILED May 27, 1941 M. M. Brown Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 26 1941

22. I HEREBY CERTIFY, That I attended deceased from May 15 1941, to May 26 1941
I last saw h. alive on May 26 1941. Death is said to have occurred on the date stated above, at 6:18 a.m.

The principal cause of death and related causes of importance were as follows:

Acute Parenchymatous Nephritis Date of onset 48 to 54 hrs

Other contributory causes of importance: Hypertension, Chronic Myocarditis due to fatty infiltration

Name of operation Hysterectomy Date of 5-19-41
What test confirmed diagnosis? Section Where an autopsy? yes

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? Date of injury 19

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? If so, specify.

(Signed) D. J. Graham M.D.
(Address) 8 11 Chamber

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.

629

1900-1905

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 17407

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 299

Primary Registration District No. 1002

Registrar's No. 2069

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

1. PLACE OF DEATH:

(a) County.....
(b) City or town.....
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Lakeside Hospital
(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 **Valeria Boatka**

3. (b) If veteran, name war..... 3. (c) Social Security No.....

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

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

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

8. AGE: Years Months Days If less than one day..... min

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

10. Usual occupation.....

11. Industry or business.....

12. Name.....

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

14. Maiden name.....

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

16. (a) Informant.....

(b) Address.....

17. (a)..... (b) Date thereof..... (Month) (Day) (Year)

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a) 7/18/41 (b)..... (c) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... (b) County.....
(c) City or town.....
(If outside city or town limits write "RURAL")
(d) Street No. **7014 E. 12th Terrace**
(If rural, give location)
(e) If foreign born, how long in U. S. A.?..... years.

DECLARATION OF PHYSICIAN

20. DATE OF DEATH: Month **May** day **26th** year **1941** hour..... minute..... M.

21. I hereby certify that I attended the deceased from..... 19..... 19.....
that I last saw him..... give on..... and that death occurred on the day and hour stated above.

Immediate cause of death: **acute parenchymatous Nephritis** Duration.....

Due to.....
Due to.....

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

myocarditis due to fatty infiltration

Major findings: **Hysterectomy May 19, 1941**

Of operations: **From Uterine Fibrosis.**

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?.....

While at work?..... (Specify type of place) (c) Means of injury.....

23. Signature..... (M. D. or other)

Address..... Date signed.....

SUPPLEMENTARY
For Hyperthyroidism
56B
Hypothyroidism-chronic
myocarditis due to fatty infiltration
Hysterectomy May 19, 1941
From Uterine Fibrosis.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 17407
Registrar's No. 2069

Registration District No. _____ Primary Registration District No. _____

1. PLACE OF DEATH

(a) County Jackson
(b) City or town K.C.
(c) Name of hospital or institution: Lakeside Hosp.
(d) Length of stay: In hospital or institution _____
In this community _____
years, months or days

3. (a) PRINT FULL NAME Valeria Brutha
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race w
6. (a) Single, widowed, married, divorced div
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ year

7. Birth date of deceased _____
(Month) (Day) (Year)
8. AGE: Years 32 Months _____ Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____
(b) Address _____

19. (a) 5/27/41 (b) M. M. Crown
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____
(d) Street No. _____
(e) Citizen of foreign country _____
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May Day 26 - Year 41
year _____ hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death: acute Paren nephritis
Due to: hypertension
Due to: Chr. Myocarditis
Other conditions: fatly infiltration
(include pregnancy within 3 months of death) 139 lb

Major findings: Hysterectomy 5-14-41
Of operations: Uterine fibrosis (hemorrhage)
Of autopsy: _____

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? _____
(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 Dr. J. J. Graham (M.D. or other) _____
Address 5112 E. Broadway Date signed 5/27/41

SUPPLEMENTARY

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

MOTHER FATHER