No. 2
-1-4-41
-17-39
X26390

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED OCT 10 1941

Registration District No. 3947

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 30829

Primary Registration District No. 1002

Registrar's No. 3586

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. Joseph's 0
(If not in hospital or institution, write street number or location)

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

In this community 50 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson 28

(c) City or town Kansas City 3
(If outside city or town limits, write "RURAL")

(d) Street No. 4538 Olive 0
(If rural, give location)

(e) Citizen of foreign country? ..... (Yes or No)

If yes, name country .....

3. (a) PRINT FULL NAME John L. Kubicki

3. (b) If veteran, name war World War

3. (c) Social Security No. 486-09-8479

4. Sex Male 0

5. Color or race Wh

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

6. (b) Name of husband or wife Grace B. Kubicki

6. (c) Age of husband or wife if alive 42 years

7. Birth date of deceased Feb 2 1891 (Month) (Day) (Year)

8. AGE: Years 50 | Months 7 | Days 23 | If less than one day ..... hr. ..... min.

9. Birthplace Kansas City (City, town, or county) 0 (State or foreign country)

10. Usual occupation Carpenter

11. Industry or business Patti Const. Co.

FATHER
12. Name Frank Kubicki
13. Birthplace Poland (City, town, or county) 4 (State or foreign country)

MOTHER
14. Maiden name Elizabeth Krolich
15. Birthplace Poland (City, town, or county) 4 (State or foreign country)

16. (a) Informant Mrs. Grace Kubicki
(b) Address 4538 Olive

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-27-41 (Month) (Day) (Year)
(c) Place: burial or cremation Calvary

18. (a) Signature of funeral director Thos. E. Quirk
(b) Address 4316 Troost

19. (a) 9/26/41 (Date received local registrar) (b) M. M. Crow (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 9 day 25 year 41 hour 10/05 a.m. 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 Fracture of the Skull

Due to Fall

Due to .....

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) accident

(b) Date of occurrence 9-25-41

(c) Where did injury occur? KC Clay Mo (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? at work. City Water Works (Specify type of place)

While at work? ..... (e) Means of injury Fall

23. Signature Russell W. Fear (M. D. or other) 3

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

(Licensed Embalmer's Statement on Reverse Side)

OCT 8 1949
OCT 20 1949

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.....Thomas E. Turk

Licensed Embalmer No.....3775

P. O. Address.....K. C. Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.