

1. PLACE OF DEATH:

(a) County. Bufferson  
(b) City or town. St Joseph  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: State Hospital # 2 - 2  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution. Since Aug 1st 1940 Specify whether years, months or days

3. (a) PRINT FULL NAME Harry - ITZKOSKI.

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

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

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

7. Birth date of deceased. May 30 - 1889 -  
(Month) (Day) (Year)

8. AGE: Years 53 Months 5 Days 11 If less than one day          hr.          min.

9. Birthplace St Louis (City, town, or county) MO - 0 (State or foreign country)

10. Usual occupation Clothier

11. Industry or business Same

MOTHER FATHER  
12. Name Unknown  
13. Birthplace Russia (City, town, or county) 6 (State or foreign country)  
14. Maiden name Unknown  
15. Birthplace Russia (City, town, or county) 6 (State or foreign country)

16. (a) Informant State Hospital records

(b) Address State Hospital - St Joseph

17. (a) Removal (b) Date thereof 11-10-42  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St Louis Mo

18. (a) Signature of funeral director Flemon & Son Inc

(b) Address St Joseph Mo

19. (a) 11-10-42 (b) Arce Hayoz  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County           
(c) City or town St Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. 1508 1/2 Franklin St  
(If rural, give location)  
(e) Citizen of foreign country? Unknown (Yes or No)  
If yes, name country         

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 10th year 1942 hour 8 30 minute 9 M.

21. I hereby certify that I attended the deceased from 7/15/42 19          to 11/18/42 19         ;  
that I last saw h. live on 11/9/42 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage  
Syphilitic meningitis  
encephalitis Duration 1940

Due to Syphilis

Due to Hypertension

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

Major findings: 30 lb  
Of operations           
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?           
(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 Dr Deuker MD  
Address St Joseph Mo Date signed 11/10/42

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

11  
1  
7

*Handwritten notes at top of page, possibly including a name and date.*

*Handwritten text: "Road TX 10000"*

*Handwritten text: "April 30 1988"*

*Handwritten text: "April 30 1988"*

*Handwritten text: "St Joseph, Mo"*

**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 \_\_\_\_\_

*Handwritten signature: Robert L. [unclear]*

Licensed Embalmer No. \_\_\_\_\_

*Handwritten number: 3308*

P. O. Address \_\_\_\_\_

*Handwritten address: St Joseph, 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, fact should be so stated above.