

FILED FEB 24 1944/9

Registration District No.

Primary Registration District No. 1002

Registrar's No.

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

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas City, Missouri
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. Anthony's Home For Infants 51
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 12/29/43
(Specify whether
In this community 5 Months 10 Days
years, months or days)

3. (a) PRINT FULL NAME Thereska Skradski

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 Single

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

7. Birth date of deceased Aug. 26, 1943
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
0 5 10 hr. min.

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

10. Usual occupation None

11. Industry or business

MOTHER FATHER }
12. Name No Record
13. Birthplace 9
(City, town, or county) (State or foreign country)
14. Maiden name Ann Skradski
15. Birthplace Kansas City, Kansas
(City, town, or county) (State or foreign country)

16. (a) Informant Hospital Records

(b) Address 3210 E 23rd St

17. (a) Burial (b) Date thereof 2-7-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. St. Marys

18. (a) Signature of funeral director John W. Wagner

(b) Address Kansas City, Mo

19. (a) 2-7-44 (b) J. Brown
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
(c) City or town Kansas City, Missouri
(If outside city or town limits, write "RURAL")
(d) Street No. 3210 East 23rd Street
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country 1

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 6, 1944
year 1944 hour 10:50 A.M. minute M.

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

Immediate cause of death respiratory failure
Duration

Due to pulmonary congestion, oedema and consolidation
Due to bronchopneumonia

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations 107
Of autopsy bronchopneumonia
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 0
23. Signature Merrill Dunnett, M.D. M. D. or other)

Address Dr. Joseph Hospital Date signed 2-6-44

J. Fred Jowrey

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 *No Embalming*.....
Licensed Embalmer No.....

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, fact should be so stated above.