S. No. 2
M—9-4-41
v. 5-17-39
PI X29484

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

6930

State File No. 6930

FILED MAR 15 1944

Registration District No. 71 Primary Registration District No. 3012 Registrar's No. 27

1. PLACE OF DEATH:
(a) County: Clay
(b) City or town: Excelsior Springs, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Veterans Administration Facility
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: 9 mos. 22 days (Specify whether years, months or days)
In this community: 9 mos. 22 days

2. USUAL RESIDENCE OF DEACESED: 999
(a) State: Indiana (b) County: 12
(c) City or town: South Bend
(If outside city or town limits, write "RURAL")
(d) Street No.: 721 - 36th St.
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country: 2

3. (a) PRINT FULL NAME: Adolt YWAK

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

3. (c) Social Security No.: None

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 17, 1892 (Month) (Day) (Year)

8. AGE: Years 51 Months 9 Days 5 If less than one day hr. min.

9. Birthplace: ~~Germany~~ (City, town, or county) Germany 4 (State or foreign country)

10. Usual occupation: Fruit & vegetable vender

11. Industry or business: " " "

MOTHER FATHER
12. Name: Louie Ywak
13. Birthplace: — (City, town, or county) Germany 4 (State or foreign country)

MOTHER
14. Maiden name: Mollie ?
15. Birthplace: — (City, town, or county) Poland 4 (State or foreign country)

16. (a) Informant: Hospital Records, Veterans Administration, Excelsior Springs, Mo.
(b) Address:

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof: 2-23-44 (Month) (Day) (Year)
(c) Place: burial or cremation: Removed to: South Bend, Indiana

18. (a) Signature of funeral director: HERBERT HOPE
(b) Address: Excelsior Springs, Mo.

19. (a) 2-23-44 (Date received local registrar) (b) Mrs Sacha Redman (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 22 year 1944 hour 2:40 minute A. M.

21. I hereby certify that I attended the deceased from May 1, 1943 to February 22, 1944 that I last saw him alive on February 22, 1944 and that death occurred on the date and hour stated above.

Immediate cause of death: Pulmonary Tuberculosis, chronic, far advanced, severe — Duration: unknown

Due to: 131

Due to:

Other conditions (Include pregnancy within 3 months of death): Pulmonary Emphysema, bilateral — Duration: unknown

Major findings:
Of operations:
Of autopsy: NO 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? —
(Specify type of place)
While at work? (e) Means of injury: —

23. Signature: Chas J. Hufnagel (M. D. or other) MD
Address: CHAS. J. HUFNAGEL, Veterans Administration Date signed 2-22-44
Excelsior Springs, Mo.

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(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
Health Officer No: 8
Number
Date Filed 3-9-44

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 J. A. Moles

Licensed Embalmer No. 3296

P. O. Address Excelsior Springs M

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.