

FILED DEC 7 1944

Registration District No.

Primary Registration District No.

Registrar's No.

1195

1. PLACE OF DEATH:

(a) County Buchanan  
(b) City or town St. Joseph  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: St. Joseph's Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 1 Hour 25 Min.  
(Specify whether  
In this community 38 Years  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan  
(c) City or town St. Joseph  
(If outside city or town limits, write "RURAL")  
(d) Street No. 311 Ohio  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Mary M. Tworek

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. 487-09-1775

4. Sex Female 5. Color or race White  
6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife John W. Tworek  
6. (c) Age of husband or wife if alive 62 years  
7. Birth date of deceased September 6 1888  
(Month) (Day) (Year)

8. AGE: Years 56 Months 2 Days 29  
If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation Pork Trimmer

11. Industry or business Armour & Co.

12. Name John Marek  
13. Birthplace Unknown Poland  
(City, town, or county) (State or foreign country)  
14. Maiden name Anna Kaczak  
15. Birthplace Unknown Poland  
(City, town, or county) (State or foreign country)

16. (a) Informant Mr. John W. Tworek  
(b) Address 311 Ohio St.

17. (a) Burial (b) Date thereof Dec. 9, 1944  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Olivet Cemetery

18. (c) Signature of funeral director Norman W. Sidenfaden

(b) Address 1802 Union St. St. Joseph, Mo.

19. (a) 12-6-44 (b) Norman W. Sidenfaden  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 5  
year 1944 hour 55 minute \_\_\_\_\_ A. M.

21. I hereby certify that I attended the deceased from Dec 4 1944 to Dec 5 1944  
that I last saw him alive on Dec 5 1944  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage Duration 6 hrs.

Due to Hypertensive arteriosclerotic  
cardiovascular disease

Due to \_\_\_\_\_  
Other conditions Uterine Fibroid  
(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_  
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 MD

23. Signature Ed Grant (M. D. or other) \_\_\_\_\_  
Address St. Joseph, Mo Date signed 12-5-44

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

MOTHER FATHER

1377

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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

*Herman W. Sidenfader*

Licensed Embalmer No. *2728*

P. O. 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.**