

Registration District No. 21 Primary Registration District No. 3012

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: Excelsior Springs Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 days (Specify whether
In this community 2 years
years, months or days)

3. (a) PRINT FULL NAME ROSE ZELINSKI
3. (b) If veteran, name war.....
3. (c) Social Security No.....

4. Sex Female 5. Color or race white
6. (a) Single, widowed, married, divorced widowed
6. (b) Name of husband or wife John Zelinski 6. (c) Age of husband or wife if alive dead years
Birth date of deceased Sept 26 - 1856
(Month) (Day) (Year)

8. AGE: Years 88 Months 3 Days 14 If less than one day hr. min.

9. Birthplace Pollard (City, town, or county) 4 (State or foreign country)

10. Usual occupation.....
11. Industry or business.....

MOTHER FATHER
12. Name unknown
13. Birthplace Pollard (City, town, or county) (State or foreign country) 4
14. Maiden name Don't know
15. Birthplace Pollard (City, town, or county) (State or foreign country) 4

16. (a) Informant Joe Zelinski
(b) Address Excelsior Spgs Mo
17. (a) Removal (b) Date thereof 11-10-44
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Leavenworth Kans

18. (c) Signature of funeral director Herbert Hope
(b) Address Excelsior Springs Mo
19. (a) 11-10-44 (b) Mrs Sadie Redman
(Data received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Clay 24
(c) City or town Excelsior Springs
(If outside city or town limits, write "RURAL" and name of township)
(d) Street No. 576 1/2 N. Edwards
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country 0

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Nov day 10
year 1944 hour 2 minute P M.

21. I hereby certify that I attended the deceased from Nov 7, 1944, to Nov 10, 1944
that I last saw 2 alive on Nov 10, 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia Duration
Pneumonia

Due to Cerebral
Accident
Due to Arteriosclerosis Changes

Other conditions Extreme age
(Include pregnancy within 3 months of death)

Major findings:
Of operations §3a
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?

(Specify type of place) (b) Means of injury
While at work.....
23. Signature O.E. Baird (M. D. or other)
Address Excelsior Springs Date signed Nov 10 - 44

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

RECEIVED

District Health Officer No. 8, -

District File Number _____

Date Filed _____

12-7-47

DEC 7 1947

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 James A. Mole

Licensed Embalmer No. 3296

P. O. Address Ex Springs, Wis.

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 1111

Registration District No. 71

Primary Registration District No. 3012

Registrar's No. 154

1. PLACE OF DEATH:

(a) County Clay

(b) City or town Excelsior Springs
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
(Specify whether)

In this community _____
years, months or days

3. (a) PRINT FULL NAME Rose Zelinski

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex F

5. Color or race W

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

6. (b) Name of husband or wife _____

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

7. Birth date of deceased: Sept 26 1888
(Month) (Day) (Year)

8. AGE: Years 88 Months 2 Days _____
If less than one day _____ min.

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

10. Usual occupation Housewife

11. Industry or business Home

12. Name _____

13. Birthplace _____
(City, town, or county) (State or foreign country)

14. Maiden name _____

15. Birthplace _____
(City, town, or county) (State or foreign country)

16. (a) Informant _____

(b) Address _____

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) Mrs Sadie Redman
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____

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

(d) Street No. _____
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov Day 15 Year 1988 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____
that last saw him/her alive on _____, 19____
and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to _____

Due to _____

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

PHYSICIAN

Major findings:
Of operations _____

Of autopsy _____

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 _____ (M. D. or other) _____
Address _____ Date signed _____

SUPPLEMENTARY

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

37512