

FILED JAN 8 1946

Registration District No. **42**

Primary Registration District No. **1000**

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: **Mo. Methodist Hospital**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **1 day**
(Specify whether
In this community **45 years**
years, months or days)

3. (a) PRINT FULL NAME

Antonia Zmek

3. (b) If veteran,
name was **none**

3. (c) Social Security
No. **500-07-3780**

4. Sex **female** 5. Color or race **white** 6. (a) Single, widowed, married, divorced **widow**
6. (b) Name of husband or wife **Joseph Zmek** 6. (c) Age of husband or wife if alive **17** years
7. Birth date of deceased **January 17 1875**
(Month) (Day) (Year)

8. AGE: Years **70** Months **11** Days **7** If less than one day
hr. min.

9. Birthplace **unknown** **Austria**
(City, town, or county) (State or foreign country)

10. Usual occupation **furrier**

11. Industry or business **Princess Clothing Store**

12. Name **Frank Bowska**

13. Birthplace **unknown** **Austria**
(City, town, or county) (State or foreign country)

14. Maiden name **Frances Christian**

15. Birthplace **unknown** **Austria**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. R. B. Pierce**

(b) Address **St. Joseph, Mo.**

17. (a) **burial** (b) Date thereof **12/28/45**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Memorial Park**

18. (a) Signature of funeral director **Heater B. Bole & Bowers**

(b) Address **319 So. 10th**

19. (a) **Jan 2-1946** (b) **X. J. Mathews**
(Date received local registrar) (Registrar's signature)

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. **1633** **--6th Ave.**
(If rural, give location)
(e) Citizen of foreign country? **no** (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **12** day **24**
year **1945** hour **6** minute **8** P.M.

21. I hereby certify that I attended the deceased from **Dec. 17** 1945 to **Dec. 22** 1945
that I last saw him alive on **Dec 22** 1945
and that death occurred on the date and hour stated above.

Immediate cause of death **myocardial insufficiency** Duration **unknown**

Due to **Influenza** **7 ds**

Due to **Arteriosclerosis general** **unknown**

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations **h3h**

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 **Justin Han** (M. D. or other) **h3**
Address **St. Joseph, Mo.** Date signed **1/2/46**

Mr. Earl Lester
722 1/2 Francis

FEB 4 1948

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 _____

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.