

No. 2  
-2.43  
-17-39  
X35697

**FILED FEB 11 1946**

Registration District No. 242

Primary Registration District No. 1000

Registrar's No. 9

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: 3013 South 29th St  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution none  
(Specify whether years, months or days)  
In this community 33 years

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. 3013 South 29th St  
(If rural, give location)  
(e) Citizen of foreign country? no (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Caroline Mary Krawczyk

3. (b) If veteran, name war none 3. (c) Social Security No. none

4. Sex Female 5. Color or race white 6. (a) Single, widowed, married, divorced Wid.

6. (b) Name of husband or wife Michael 6. (c) Age of husband or wife if alive 36 years

7. Birth date of deceased July 20, 1876  
(Month) (Day) (Year)

8. AGE: Years 69 Months 5 Days 13 If less than one day hr. min.

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

10. Usual occupation housewife Poland

11. Industry or business unknown

12. Name \_\_\_\_\_

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

14. Maiden name unknown

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

16. (a) Informant Frank E. Krawczyk

(b) Address 3009 So 29th St, St. Joseph, Mo

17. (a) Burial (b) Date thereof 1-7-46  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt Olivet Cemetery

18. (a) Signature of funeral director Barry Funeral Home  
(b) Address St. Joseph, Mo.

19. (a) Jan 9, 1946 (b) [Signature]  
(Date received local register) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 3  
year 1946 hour 6 minute 30 P.M.

21. I hereby certify that I attended the deceased from December 31  
1945 to January 3 1946  
that I last saw her alive on January 3 1946  
and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_  
Heart failure

Due to chronic myo carditis  
Pneumonia

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

**ADDITIONAL  
SUPPLEMENTARY  
INFORMATION  
REQUESTED**

Duration \_\_\_\_\_  
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) 1  
(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 E. Henderson (M. D. or other)  
Address Physician + Law firm Building Date signed 4/5/46

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

MOTHER FATHER

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St. Joseph Mo.

**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 *Mollie E. Sidenfaden Fro*

Licensed Embalmer No. *4235*

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.**

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

2. USUAL RESIDENCE OF DECEASED:  
(a) State..... (b) County 9  
(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.....

3. (a) PRINT FULL NAME Caroline M. Krawczyk  
3. (b) If veteran, name war..... 3. (c) Social Security No. 427

20. DATE OF DEATH: Month Jan day 3  
year 1942 hour..... minute..... M.  
21. I hereby certify that I attended the deceased from..... to....., 19.....  
that I last saw him..... alive on....., 19.....  
and that death occurred on the date and hour stated above.  
Immediate cause of death.....

4. Sex F 5. Color or race w 6. (a) Single, widowed, married, divorced wid  
6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive..... years  
7. Birth date of deceased July 20 1872  
(Month) (Day) (Year)

Due to Heart failure  
Lobar Pneumonia  
Due to.....  
Other conditions.....  
(Include pregnancy within 3 months of death)

8. AGE: Years 69 Months..... Days..... If less than one day hr. min.  
9. Birthplace Poland  
(City, town, or county) (State or foreign country)

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED  
Major findings: Of operations.....  
Of autopsy 108  
PHYSICIAN  
Underline the cause to which death should be charged statistically.

10. Usual occupation.....  
11. Industry or business.....  
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) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)  
(c) Place: burial or cremation.....  
18. (a) Signature of funeral director..... (b) Address.....  
19. (a) (Date received local registrar) (b) (Registrar's signature)

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) (c) Means of injury.....  
23. Signature E. H. Under A.D. (M.D. or other)  
Address Physician J. J. Field Date signed 4/14/46  
St. Joseph

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

SUPPLEMENTARY 3

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