S. No. 2
M—5-43
7. 5-17-39
o I X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 19 1946

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 8831

Registration District No. _____ Primary Registration District No. 3012 Registrar's No. 33

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: Ball Sanitarium (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 mo. 11 days (Specify whether years, months or days) In this community _____

2. USUAL RESIDENCE OF DECEASED:
(a) State Wisconsin (b) County Milwaukee
(c) City or town West Allis (If outside city or town limits, write "RURAL")
(d) Street No. 1642 South 65 St. (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Julius L. Makowski
3. (b) If veteran, name war _____
3. (c) Social Security No. _____
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 Unknown (Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
49			hr. min.

9. Birthplace Unknown (City, town, or county) (State or foreign country)
10. Usual occupation Priest
11. Industry or business _____
FATHER 12. Name Unknown
13. Birthplace _____ (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name Unknown
15. Birthplace _____ (City, town, or county) (State or foreign country)
16. (a) Informant Hospital Records
(b) Address Excelsior Springs, Mo.
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 3-4-46 (Month) (Day) (Year)
(c) Place: burial or cremation Milwaukee, Wis.
18. (a) Signature of funeral director Claude Prichard
(b) Address Excelsior Springs, Mo.
19. (a) 3-11-46 (Date received local registrar) (b) Caroline Hutchings (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mch. day 3rd year 1946 hour 5 minute 30 P.M.
21. I hereby certify that I attended the deceased from 1-22-46, 19____, to 3-3-, 19 46, that I last saw him alive on Mch. 3, 1946, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Embolism
Embolism
Due to Senile changes in the heart, and Cardiac
Due to Hypertension

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy None

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) _____
(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 W. G. Permance M.D. (M.D. or other)
Address Ball Clinic, Excelsior Springs, Mo. Date signed 3-4-46

62 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 3-15-46

MAR 29 1946

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 E. E. White

Licensed Embalmer No. 4168

P. O. Address Excelsior Springs, 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.