S. No. 2
M—2-43
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X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED SEP 23 1946

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 30015

Registration District No. 128 | Primary Registration District No. 2000 | Registrar's No. 736

9
2
6

1. PLACE OF DEATH:

(a) County: Greene

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

(c) Name of hospital or institution: 1842 S. Fremont
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ____ (Specify whether years, months or days)
In this community: 2 months

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Polk 84

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

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

(e) Citizen of foreign country? No (Yes or No)

If yes, name country ____

3. (a) PRINT FULL NAME: John Kukal

3. (b) If veteran, name war: UNK.

3. (c) Social Security No. UNK.

4. Sex: male

5. Color or race: white

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

6. (b) Name of husband or wife: Anna Kukal

6. (c) Age of husband or wife if alive: 80 years

7. Birth date of deceased: May (Month) 8 (Day) 1860 (Year)

8. AGE: Years 86 | Months 3 | Days 29 | If less than one day ____ hr. ____ min.

9. Birthplace: UNK. (City, town, or county) Czechoslovakia (State or foreign country)

10. Usual occupation: Farmer

11. Industry or business: 6

MOTHER FATHER

12. Name: Frank Kukal

13. Birthplace: UNK. (City, town, or county) Czechoslovakia (State or foreign country)

14. Maiden name: Anna Materna

15. Birthplace: UNK. (City, town, or county) Czechoslovakia (State or foreign country)

16. (a) Informant: Mrs John Kukal

(b) Address: Bolivar Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: Sept. 9, 1946 (Month) (Day) (Year)

(c) Place: burial or cremation: Greenwood Cem. Bolivar, Mo.

18. (a) Signature of funeral director: Hutchison-Turpin

(b) Address: Bolivar, Mo.

19. (a) 9-9-46 (Date received local registrar) (b) W. J. Hardy M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 7 year 1946 hour 9:00 minute A. M.

21. I hereby certify that I attended the deceased from 11/4/45, 19____, to 9/3/46, 19____; that I last saw him alive on 9/3/46, 19____; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Myocarditis Chronic	
Due to:	
Due to:	
Other conditions: none (Include pregnancy within 3 months of death)	
Major findings: Of operations:	
Of autopsy: none	

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: Leslie R. Webb (M. D. or other)

Address: Springfield, Mo. Date signed 9/7/46

(Licensed Embalmer's Statement on Reverse Side)

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. 3053

P. O. Address Bolivar 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.