

S. No. 2
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 Rev. 5-17-39
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DEPARTMENT OF COMMERCE
 BUREAU OF THE CENSUS
FILED MAY 26 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **16565**

Registration District No. **42**

Primary Registration District No. **1000**

Registrar's No. **666**

1. PLACE OF DEATH:
 (a) County **Buchanan**
 (b) City or town **St. Joseph Mo.**
 (c) Name of hospital or institution
 (If outside city or town limits, write "RURAL" and name of township)
I025 South 23rd Street
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **None**
 In this community **63 Years**
 (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Missouri** (b) County **Buchanan**
 (c) City or town **St. Joseph Mo.**
 (If outside city or town limits, write "RURAL")
 (d) Street No. **I025 South 23rd Street**
 (If rural, give location)
 (e) Citizen of foreign country? **Nos** (Yes or No)
 If yes, name country **Poland**

3. (a) PRINT FULL NAME **Magdalen Kalinowski**
 3. (b) If veteran, name war **No**
 3. (c) Social Security No. **None**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **May** day **17**
 year **1947** hour **8** minute **25** P.M.

4. Sex **Female** 5. Color or race **White**
 6. (a) Single, widowed, married, divorced **Widowed**
 6. (b) Name of husband or wife **Frank**
 6. (c) Age of husband or wife if alive **years**
 7. Birth date of deceased **May 14 1862**
 (Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **Oct 8**
1946, to **May 17**, 19**47**
 that I last saw her alive on **May 17**, 19**47**
 and that death occurred on the date and hour stated above.

8. AGE: Years **85** Months **0** Days **3**
 If less than one day hr. min.

Immediate cause of death **Chronic myocardial insufficiency**
 Due to **arteriosclerosis general**
 Due to **chronic hypertension**

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

Other conditions (Include pregnancy within 3 months of death)

10. Usual occupation **None**
11. Industry or business **None**
12. Name **Unknown**
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)

Major findings:
 Of operations
 Of autopsy
PHYSICIAN
 Underline the cause to which death should be charged statistically.

16. (a) Informant **Mr. Wm. J. Kalinowski**
 (b) Address **1025 So. 23rd. St. City**
17. (a) Burial (b) Date thereof **May 20, 1947**
 (Burial, cremation, or removal) (Month) (Day) (Year)

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?

(c) Place: burial or cremation **Mt. Olivet Cemetery**
18. (a) Signature of funeral director **Herward W. Adolphow**
 (b) Address **1802 Union St. St. Joseph, Mo.**
19. (a) 5-21-47 (b) **G. L. Jenkins**
 (Date received local registrar) (Registrar's signature)

While at work? (Specify type of place) (e) Means of injury
23. Signature **Luister Han** (M. D. or other) **MA**
 Address **Lincoln Blvd. St. Joseph** Date signed **5/19/46**

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

MOTHER FATHER

MAY 27 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.....
James W. O'Clanchan Registered Apprentice No. *486*
working under my personal supervision.

Signed.....

Robert L. Gable
Licensed Embalmer No. *3308*

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.