

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
310 So. Lawndale
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community since 1915
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 310 So. Lawndale
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME

STANLEY LEO KUBIAK

3. (b) If veteran, name war no

3. (c) Social Security No. 486-05-1029

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 3 year 1947 hour 6 minute 40 P. M.

21. I hereby certify that I attended the deceased from Dec.

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced married
7. Birth date of deceased November 5 1880
(Month) (Day) (Year)

that I last saw him 4 alive on 6-28 and that death occurred on the date and hour stated above.

Immediate cause of death Carying of

rupture of vessel

Duration

8. AGE: Years 66 Months 7 Days 15 If less than one day hr. _____ min. _____

Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations 40%

Of autopsy no

PHYSICIAN

Underline the cause to which death should be charged statistically.

MOTHER FATHER

12. Name Stanley Kubiak
13. Birthplace Poland
(City, town, or county) (State or foreign country)
14. Maiden name unknown
15. Birthplace _____
(City, town, or county) (State or foreign country)

16. (a) Informant Ann Kubiak
(b) Address 310 So. Lawndale
17. (a) Burial (b) Date thereof 7-7-1947
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Floral Hills

18. (a) Signature of funeral director C.H. Blackman & Son, Inc
(b) Address 2825 Independence Blvd.

19. (a) 7-7-47 (b) Geraldine Holmes
(Date received local registrar) (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) (e) Means of injury C

23. Signature [Signature] (M. D. or other) 3
Address [Address] Date signed 7/6/47

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

Dr Donald Block

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 *O. K. McFarland*
Licensed Embalmer No. *4397*
P. O. Address *Kansas City 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.