

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **25546**

FILED AUG 30 1948

1000

Registrar's No. **897**

Registration District No. **42**

Primary Registration District No.

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 **918 W. Valley St.**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **46 years**
(Specify whether years, months or days)

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. **906 W. Valley St.**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country **Naturalized Pole**

3. (a) PRINT FULL NAME **JOHN WALKOWIAK**

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

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **Rosa** 6. (c) Age of husband or wife if alive **70** years
7. Birth date of deceased **July 25, 1871**
(Month) (Day) (Year)

8. AGE: Years **77** Months **0** Days **25** If less than one day hr. min.

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

10. Usual occupation **Retired Butcher**
Armour Packing Co.

11. Industry or business
12. Name **Jacob Walkowiak**
13. Birthplace **Unknown** **Poland**
(City, town, or county?) (State or foreign country)
14. Maiden name **Mary**
15. Birthplace **Unknown** **Poland**
(City, town, or county) (State or foreign country)

16. (a) Informant **Theodore Walkowiak (son)**
(b) Address **918 W. Valley St., City**
17. (a) **Burial** (b) Date thereof **8/23/48**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Mt. Olivet Cemetery**
18. (a) Signature of funeral director **John Duff**
(b) Address **6954 Pryor Ave., City**
19. (a) **P-36-48** (b) **L. B. Jenkins**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **August** day **20,**
year **1948** hour **7** minute **:10 A.M.**

21. I hereby certify that I attended the deceased from **Aug 5, 1948** to **Aug 20, 1948**
that I last saw him alive on **August 18, 1948**
and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral Hemorrhage (left)**
Compensative Heart Failure

Duration

4 days

Due to
Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations **95**
Of autopsy

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) (e) Means of injury
23. Signature **J. J. Franklin** (M. D. or other) **no**
Address **Paterson 327** Date signed **8-23-48**

St. Joseph, Mo.

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

10
17
19
906

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.....

Grandal R. Stabe

Registered Apprentice No. *212*

working under my personal supervision.

Signed.....

John E. Rupp

Licensed Embalmer No. *3986*

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.