

FILED APR 29 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

12918

State File No. ....

BIRTH NO. 124 REG. DIST. NO. 163 PRIMARY REG. DIST. NO. 5592 Registrar's No. 22

|                                                                                                                                      |  |                                                                                                                                    |  |
|--------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Jefferson</u>                                                                                      |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>a. STATE <u>Mo</u> b. COUNTY <u>Jeff.</u> |  |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>De Soto Rural, Plattin</u>                           |  | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>De Soto Mo, Route # 1</u>                          |  |
| c. LENGTH OF STAY (in this place) <u>30yrs</u>                                                                                       |  | d. STREET ADDRESS (If rural, give location) <u>Rural, Route # 1</u>                                                                |  |
| d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>Rural, Route # 1</u> |  |                                                                                                                                    |  |

|                                                                                                                    |                           |                                                        |                                                              |                                                         |                             |                                           |
|--------------------------------------------------------------------------------------------------------------------|---------------------------|--------------------------------------------------------|--------------------------------------------------------------|---------------------------------------------------------|-----------------------------|-------------------------------------------|
| 3. NAME OF DECEASED (Type or Print)<br>a. (First) <u>Joseph</u> b. (Middle) <u>John</u> c. (Last) <u>Kozloski</u>  |                           |                                                        | 4. DATE OF DEATH (Month) (Day) (Year) <u>April, 16, 1949</u> |                                                         |                             |                                           |
| 5. SEX <u>MO</u>                                                                                                   | 6. COLOR OR RACE <u>W</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH <u>JAN. 1st 1865</u>                        | 9. AGE (in years last birthday) <u>84</u>               | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.               |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer, Retired</u> |                           | 10b. KIND OF BUSINESS OR INDUSTRY <u>Self</u>          |                                                              | 11. BIRTHPLACE (State or foreign country) <u>Poland</u> |                             | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u> |

|                                                                                                                    |  |                                          |  |                                                                                         |  |
|--------------------------------------------------------------------------------------------------------------------|--|------------------------------------------|--|-----------------------------------------------------------------------------------------|--|
| 13a. FATHER'S NAME <u>Michael Kozloski</u>                                                                         |  | 13b. MOTHER'S MAIDEN NAME <u>UNKNOWN</u> |  | 14. NAME OF HUSBAND OR WIFE <u>Rose Wzientozczak</u>                                    |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> |  | 16. SOCIAL SECURITY NO. <u>No</u>        |  | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Miss Ann Kozloski, Lee 3070, Route # 1</u> |  |

|                                                                                                                                                |  |                                                                                                             |  |  |                                  |  |
|------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------|--|--|----------------------------------|--|
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)                                                                      |  | MEDICAL CERTIFICATION                                                                                       |  |  | INTERVAL BETWEEN ONSET AND DEATH |  |
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cirrhosis of the liver</u>                                                           |  | DUE TO (b) _____                                                                                            |  |  |                                  |  |
| *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death. |  | DUE TO (c) _____                                                                                            |  |  |                                  |  |
| II. OTHER SIGNIFICANT CONDITIONS <u>Cardiovascular disease</u>                                                                                 |  | Conditions contributing to the death but not related to the disease or condition causing death. <u>5810</u> |  |  |                                  |  |

|                        |  |                                  |  |  |                                                                                  |  |
|------------------------|--|----------------------------------|--|--|----------------------------------------------------------------------------------|--|
| 19a. DATE OF OPERATION |  | 19b. MAJOR FINDINGS OF OPERATION |  |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
|------------------------|--|----------------------------------|--|--|----------------------------------------------------------------------------------|--|

|                                                    |  |                                                                                                        |  |                                                 |  |
|----------------------------------------------------|--|--------------------------------------------------------------------------------------------------------|--|-------------------------------------------------|--|
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify)           |  | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)               |  | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) |  |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m. |  | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |  | 21f. HOW DID INJURY OCCUR?                      |  |

22. I hereby certify that I attended the deceased from 2/3/49, to 4/14/49, that I last saw the deceased alive on 4/14/49, and that death occurred at 5:30 a.m., from the causes and on the date stated above.

|                                                               |  |                                 |  |                                 |  |
|---------------------------------------------------------------|--|---------------------------------|--|---------------------------------|--|
| 23a. SIGNATURE (Degree or title) <u>Beatalan Belgov, M.D.</u> |  | 23b. ADDRESS <u>Jeslna, Mo.</u> |  | 23c. DATE SIGNED <u>4-18-49</u> |  |
|---------------------------------------------------------------|--|---------------------------------|--|---------------------------------|--|

|                                           |  |                                |  |                                                               |  |                                                                   |  |
|-------------------------------------------|--|--------------------------------|--|---------------------------------------------------------------|--|-------------------------------------------------------------------|--|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) |  | 24b. DATE <u>April 18th 49</u> |  | 24c. NAME OF CEMETERY OR CREMATORY <u>Calvary, De Soto Mo</u> |  | 24d. LOCATION (City, town, or county) (State) <u>De Soto, Mo.</u> |  |
|-------------------------------------------|--|--------------------------------|--|---------------------------------------------------------------|--|-------------------------------------------------------------------|--|

|                                         |  |                                           |  |                                                                               |  |
|-----------------------------------------|--|-------------------------------------------|--|-------------------------------------------------------------------------------|--|
| DATE REC'D BY LOCAL REG. <u>4/23-49</u> |  | REGISTRAR'S SIGNATURE <u>Marie Harris</u> |  | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>J. E. Motherhead, De Soto Mo.</u> |  |
|-----------------------------------------|--|-------------------------------------------|--|-------------------------------------------------------------------------------|--|

(Licensed Embalmer Statement on Reverse Side)

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

RECEIVED  
District Health Officer No. 9,  
District File Number  
Date Filed - APR 28 1949

APR 29 1949

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 \_\_\_\_\_

*Andrew H. England*

Student Embalmer No. *237*

working under my personal supervision.

Student .....  
Student Embalmer

Signed *Jess Mothershead*

Licensed Embalmer No. *3531*

P. O. Address *Detroit mi*

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.