

FILED JUL 30 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **23481**
2894

BIRTH NO. _____		REG. DIST. NO. <u>149</u>		PRIMARY REG. DIST. NO. <u>1002</u>		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY <u>JACKSON</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u> <u>Mo.</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>KANSAS CITY</u>		c. LENGTH OF STAY (In this place) <u>45 Yr</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>310 So. Lawndale K. C.</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Trinity Lutheran</u> <u>11</u>				d. STREET ADDRESS (If rural, give location) <u>6</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>PAULINE</u> b. (Middle) <u>(JANOSIK)</u> c. (Last) <u>KUBIAK</u>			4. DATE OF DEATH (Month) <u>7</u> (Day) <u>3</u> (Year) <u>49</u>				
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>WIDOWED</u> <u>✓</u>	8. DATE OF BIRTH <u>1-6-1990</u>	9. AGE (In years last birthday) <u>59</u>	IF UNDER 1 YEAR Months	IF UNDER 2 HRS. Hours	IF UNDER 15 MIN. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cook (retired)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Clique Cafe</u>		11. BIRTHPLACE (State or foreign country) <u>Austria</u> <u>4</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>Frank Tonsilik</u>			13b. MOTHER'S MAIDEN NAME <u>Unknown</u>		14. NAME OF HUSBAND OR WIFE <u>Stanley Kubiak</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>496-05-7131</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Julia Spohn 310 S. Lawndale</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Carcinoma left Ovary 6415</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Generalized Carcinomatosis</u> DUE TO (c) <u>of all intraabdominal</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Organs - Terminal Intes-</u>					INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>tinal Obstruction 175</u>					20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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) (Min.)		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 <u>April</u> , 19 <u>49</u> , to <u>July</u> , 19 <u>49</u> , that I last saw the deceased alive on <u>July 2</u> , 19 <u>49</u> , and that death occurred at _____ m., from the causes and on the date stated above.							
23a. SIGNATURE <u>John H. Ogilvie</u> (Degree or title) <u>MD</u>				23b. ADDRESS <u>730 Prof Bldg. KCMU</u>		23c. DATE SIGNED <u>7/5/49</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>7-6-49</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Floral Hills</u>		24d. LOCATION (City, town, or county) (State) <u>Kansas City Missouri</u>		
DATE REC'D BY LOCAL REG. <u>7-5-49</u>		REGISTRAR'S SIGNATURE <u>Sheraldine Holmes</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>C.H. Blackman & Son Inc. K.C., Mo.</u>			

(Licensed Embalmer's Statement on Reverse Side)

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

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 _____

..... Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed W. B. Blackman

Licensed Embalmer No. 3639

P. O. Address KC 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.