

FILED OCT 30 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 32734

BIRTH NO.		REG. DIST. NO. 42		PRIMARY REG. DIST. NO. 5123		Registrar's No. 1180			
1. PLACE OF DEATH a. COUNTY Buchanan				2. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission). a. STATE Missouri b. COUNTY Buchanan					
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Rural Agency Twp.		c. LENGTH OF STAY (In this place) 30 Min.		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St Joseph, 0117					
d. FULL NAME OF HOSPITAL OR INSTITUTION 2 1/2 Miles So. E of Agency, Mo.				d. STREET ADDRESS (If rural, give location) 1919 South 20th					
3. NAME OF DECEASED (Type or Print) a. (First) Walter		b. (Middle) Joseph		c. (Last) Buczek		4. DATE OF DEATH (Month) (Day) (Year) Oct. 22, 1950			
5. SEX Male 0		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married /		8. DATE OF BIRTH March 30, 1919 31			
9. AGE (In years last birthday)		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman Beef Cooler		10b. KIND OF BUSINESS OR INDUSTRY Dugdale Pkng. Co.		11. BIRTHPLACE (State or foreign country) St Joseph, Mo.			
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME Frank Buczek		13b. MOTHER'S MAIDEN NAME Dora Kaczak		14. NAME OF HUSBAND OR WIFE Josephine F.			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. World War II 491-10-7414		17. INFORMANT'S SIGNATURE OR NAME Mrs Josephine F. Buczek		ADDRESS St Joseph			
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, asthenia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Basal Skull Fracture ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Fracture of the superior and inferior maxillary bones DUE TO (c) Fracture of the 6-7-8th ribs on right side II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Fracture of the left tibia and fibula Numerous cuts and bruises on body				INTERVAL BETWEEN ONSET AND DEATH 1 day 3-8 hrs 30	
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) Accident		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Farm		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) Agency Twp. Buchanan Mo					
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) 10-22-50 11:50a		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? Airplane Crash					
22. I hereby certify that I certified viewed the deceased person on Oct. 22, 1950 at 11:50a to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____, from the causes and on the date stated above.									
23a. SIGNATURE H. F. Mundy M.D. (Physician)				23b. ADDRESS St Joseph Mo		23c. DATE SIGNED 10/23/50			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial <input checked="" type="checkbox"/>		24b. DATE Oct. 25, 50		24c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		24d. LOCATION (City, town, or county) (State) St. Joseph, Mo.			
DATE REC'D BY LOCAL REG. Oct 25, 1950		REGISTRAR'S SIGNATURE 446 Carl C. Castel		25. FUNERAL DIRECTOR'S SIGNATURE Norman W. Eidenfaden		ADDRESS 1802 Union St			

(Licensed Embalmer's Statement on Reverse Side)

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

No. 300

10. 48

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096106 1950

NOV 21 1950

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.

Signed _____

Robert H. Yapple

Signed _____
Student Embalmer

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.