S. No. 300
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FILED APR 9 1951

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 7584

BIRTH NO. _____ REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 1000 Registrar's No. 369

0117

1. PLACE OF DEATH
a. COUNTY Buchanan
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) St. Joseph
c. LENGTH OF STAY (In this place) 33 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 323 Ohio St. (Home)

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Missouri b. COUNTY Buchanan
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) St. Joseph 0117
d. STREET ADDRESS (If rural, give location) 323 Ohio St.

3. NAME OF DECEASED (Type or Print) a. (First) JOHN b. (Middle) c. (Last) KIZIOR

4. DATE OF DEATH (Month) 4 (Day) 3 (Year) 1951

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH 5-16-1891
9. AGE (In years last birthday) 59 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) Laborer
10b. KIND OF BUSINESS OR INDUSTRY C.B. & Q. R.R.
11. BIRTHPLACE (State or foreign country) Poland 4
12. CITIZEN OF WHAT COUNTRY? USA (Nat)

13a. FATHER'S NAME Stanley Kizior
13b. MOTHER'S MAIDEN NAME Unknown
14. NAME OF HUSBAND OR WIFE Caroline Kizior

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT'S SIGNATURE OR NAME ADDRESS Stanley Kizior, St. Joseph, Mo.

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) Cerebral Apoplexy

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) ##
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Arteriosclerosis

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION ## 334X
20. AUTOPSY? YES ☐ NO ☒ No

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 ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I* Viewed *attended the deceased from* 4/3/51, 19__, *to* _____, 19__, *that I last saw the deceased alive on* _____, 19__, *and that death occurred at* 6:30A *m., from the causes and on the date stated above.*

23a. SIGNATURE B. W. Tadlock (Degree or title) Act 3 Coroner
23b. ADDRESS King Hill Bldg
23c. DATE SIGNED 4/3 "51

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 4-5-1951
24c. NAME OF CEMETERY OR CREMATORY Mt. Olivet
24d. LOCATION (City, town, or county) (State) St. Joseph, Missouri

DATE REC'D BY LOCAL REG. April 5, 1951
REGISTRAR'S SIGNATURE Carl C. Cas[illegible] 446
25. FUNERAL DIRECTOR'S SIGNATURE John E. Kupp ADDRESS St. Joseph, Mo.

(Licensed Embalmer's Statement on Reverse Side)

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

APR 11 19

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~~ .....

.....

working under my personal supervision.

Student Embalmer No. .....

Signed ..... John E. Rupp

Signed .....
Student Embalmer

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.