

FILED APR 23 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

12253

State File No.

BIRTH NO. _____		REG. DIST. NO. <u>128</u>		PRIMARY REG. DIST. NO. <u>2000</u>		Registrar's No. <u>330</u>	
1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).			
a. COUNTY <u>Greene</u>		b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Springfield</u>		a. STATE <u>Arkansas</u>		b. COUNTY <u>Johnson</u>	
c. LENGTH OF STAY (in this place) <u>3 mo 6 da</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Clarksville, Ark.</u>					
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>Veterans Administration Hospital</u>				d. STREET ADDRESS (If rural, give location) <u>710 Roger St.</u>			
3. NAME OF DECEASED (Type or Print)		a. (First) <u>MIKE</u>		b. (Middle) (NMI) _____		c. (Last) <u>JABLONSKI</u>	
4. DATE OF DEATH		(Month) <u>April</u>		(Day) <u>13,</u>		(Year) <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>Sept. 29, 1896</u>		9. AGE (In years last birthday) <u>54</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>		11. BIRTHPLACE (State or foreign country) <u>Poland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>Frank Jablonski</u>		13b. MOTHER'S MAIDEN NAME <u>Catherine Kociuba</u>		14. NAME OF HUSBAND OR WIFE <u>Iva Jablonski</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>430327792</u>		17. INFORMANT'S SIGNATURE OR NAME <u>VA Hospital, Springfield, Mo.</u>			
18. CAUSE OF DEATH		MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
Enter only one cause per line for (a), (b), and (c)		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Bronchogenic malignancy with metastasis to skull and kidneys.</u>					
*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		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 - <u>Pagets disease, Terminal pneumonitis.</u>					
		Conditions contributing to the death but not related to the disease or condition causing death. <u>Healed tuberculosis, apices, bilateral.</u>					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
						<u>162 x A</u>	
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) (Minute)		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>Jan. 7,</u> 1951, to <u>April 13, 1951</u> , and that death occurred at <u>6:45 Pm.</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>P. L. EISELE, M.D., Chief, Professional Services,</u>				23b. ADDRESS <u>VA Hospital, Springfield, Mo.</u>		23c. DATE SIGNED <u>4-13-51</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>4/14/1951</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Unknown</u>		24d. LOCATION (City, town, or county) (State) <u>Clarksville, Arkansas</u>	
DATE REC'D BY LOCAL REG. <u>4-17-51</u>		REGISTRAR'S SIGNATURE <u>W. J. Handley</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Avre-Goodwin Funeral Serv., Spgfld, Mo.</u>			

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

1396

No. 300
10.48

JUN 7 1961

JUN 16 1961

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 To be embalmed at destination

Licensed Embalmer No. _____

P. O. Address _____

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.