

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **9263**

FILED MAR 24 1954		REG. DIST. NO. <b>174</b>	PRIMARY REG. DIST. NO. <b>5644</b>	Registrar's No. <b>22</b>
1. PLACE OF DEATH a. COUNTY <b>Lafayette</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before death.) a. STATE <b>Missouri</b> b. COUNTY <b>Lafayette</b>		
b. CITY (If outside corporate limits, write RURAL and give town or township) OR TOWN <b>Rural - Lexington</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Rural - Lexington</b>		
c. LENGTH OF STAY (in this place) <b>10 years</b>		d. STREET ADDRESS (If rural, give location) <b>4 miles S.E. of Lexington</b>		
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>4 miles S.E. of Lexington</b>		d. STREET ADDRESS <b>4 miles S.E. of Lexington</b>		
3. NAME OF DECEASED (Type or Print)		a. (First) <b>Mary</b>	b. (Middle) <b>Anna</b>	c. (Last) <b>Kuchinski</b>
4. DATE OF DEATH (Month) (Day) (Year) <b>March 4 1954</b>				
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>widowed</b>	8. DATE OF BIRTH <b>10-29-1877</b>	9. AGE (In years last birthday) <b>76</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>	11. BIRTHPLACE (State or foreign country) <b>Hartford, Conn.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13a. FATHER'S NAME <b>Martin Gosoroski</b>		13b. MOTHER'S MAIDEN NAME <b>unknown</b>	14. NAME OF HUSBAND OR WIFE <b>Albert Kuchinski</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Mrs. H. L. Speas, Lexington, Mo.</b>	
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) <b>Acute myocardial infarction</b>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>arteriosclerotic heart disease</b> DUE TO (c)  II. OTHER SIGNIFICANT CONDITIONS - Conditions contributing to the death but not related to the disease or condition causing death. <b>Carcinoma of pancreas</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Instant</b>  <b>years</b>  <b>undetermined</b>
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <b>4200 H</b>		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)		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 <b>February 12, 1954</b> , to <b>March 4, 1954</b> , that I last saw the deceased alive on <b>Feb. 3, 1954</b> , and that death occurred at <b>5:30 p.m.</b> , from the causes and on the date stated above.				
23a. SIGNATURE (Degree or title) <b>W. K. Applegate, M.D.</b>		23b. ADDRESS <b>Higginsville, Mo.</b>		23c. DATE SIGNED <b>March 4, 54</b>
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	24b. DATE <b>3-8-1954</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Catholic Cemetery</b>	24d. LOCATION (City, town, or county) (State) <b>Higginsville Mo.</b>	
DATE REC'D BY LOCAL REG. <b>3-10-54</b>	REGISTRAR'S SIGNATURE <b>Anna E. Gustafson</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>A. N. Hader</b>	ADDRESS <b>Higginsville, Mo.</b>	

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

EMAR 24 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.

Student .....  
Student Embalmer

Signed \_\_\_\_\_

*Robert R. Rickard*

Licensed Embalmer No. \_\_\_\_\_

14284

P. O. Address \_\_\_\_\_

*Higginsville, 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.