

FILED JUN 7 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **15023**

BIRTH NO. _____ REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 1000 Registrar's No. 551

1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Buchanan</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>St. Joseph</u>	c. LENGTH OF STAY (If this place) <u>Life</u>	c. CITY OR TOWN <u>St. Joseph</u>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Missouri Meth. Hospital</u>		e. STREET ADDRESS (If rural, give location) <u>6408 Washington St.</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>JOHN</u> b. (Middle) _____ c. (Last) <u>SUHOLASKI</u>		4. DATE OF DEATH (Month) <u>5</u> (Day) <u>27</u> (Year) <u>1954</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>2-2-1912</u>
9. AGE (In years last birthday) <u>42</u>		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) <u>Switchman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>C.B. & Q. R.R.</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>St. Joseph, Missouri</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13a. FATHER'S NAME <u>Joseph Suholaski</u>	

13b. MOTHER'S MAIDEN NAME <u>Katie Suholaski</u>		14. NAME OF HUSBAND OR WIFE <u>Hattie Suholaski</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Hattie Suholaski, 6408 Washington St</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 St. Joseph, Mo. INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u>	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral metastases from bronchogenic carcinoma</u>		DUE TO (b) <u>Bronchogenic carcinoma</u>	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (c) _____	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		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)		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 May 26 1954, to May 27, 1954, that I last saw the deceased alive on May 26, 1954, and that death occurred at 3:00A m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>William H. Conroy, M.D.</u>		23b. ADDRESS <u>902 Edmond St.</u>		23c. DATE SIGNED <u>May 28, 1954</u>	
24a. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>5-29-1954</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>	
24d. LOCATION (City, town, or county) (State) <u>St. Joseph, Missouri</u>		24e. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>John Rupp, St. Joseph, Mo.</u>			
DATE REC'D BY LOCAL REG. <u>June 3, 1954</u>		REGISTRAR'S SIGNATURE <u>Esther M. Allison</u>		485	

(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, ~~only~~, Student Embalmer No..... working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed.....

Licensed Embalmer No. 39

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.