

FILED DEC 20 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

40182

State File No.

| | | | | | | | | | |
|---|--|--|--|---|--|---|--|--|--|
| BIRTH NO. | | REG. DIST. NO. 42 | | PRIMARY-REG.-DIST. NO. 1000 | | Registrar's No. 1295 | | | |
| 1. PLACE OF DEATH a. COUNTY Buchanan | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo b. COUNTY Buchanan | | | | | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Joseph | | c. LENGTH OF STAY (in this place) 50yrs | | c. CITY OR TOWN St. Joseph | | 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 St. Joseph's Hospital | | | | f. STREET ADDRESS (If rural, give location) 5225 1/2 Lake Ave 0110 | | | | | |
| 3. NAME OF DECEASED (Type or Print) a. (First) Alex | | | b. (Middle) | | c. (Last) Kulak | | 4. DATE OF DEATH (Month) (Day) (Year) Dec 8 1954 | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married | | 8. DATE OF BIRTH Mar 26, 1893 | | 9. AGE (In years last birthday) 61 | |
| | | | | | | If UNDER 1 YEAR Days 8 | | If UNDER 4 HRS. Hours 12 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bartender | | | 10b. KIND OF BUSINESS OR INDUSTRY Tavern | | 11. BIRTHPLACE (City and State or Foreign Country) Poland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | |
| 13a. FATHER'S NAME Carl Kulak | | | 13b. MOTHER'S MAIDEN NAME Eva ? ? ? | | | 14. NAME OF HUSBAND OR WIFE None | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) no 499-20-3317 | | 17. INFORMANT'S SIGNATURE OR NAME Mary. Knight | | | | ADDRESS 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 Hemorrhage ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arteriosclerotic and DUE TO (c) Hypertensive heart disease II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | | | INTERVAL BETWEEN ONSET AND DEATH 10 hours 5 years | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION 331 X | | | | | | 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) m. | | 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 Dec 1, 1954, to Dec 7, 1954, that I last saw the deceased alive on Dec 7, 1954, and that death occurred at 11:50pm., from the causes and on the date stated above. | | | | | | | | | |
| 23a. SIGNATURE (Degree or title) Mohammed Sabir M.D. | | | | 23b. ADDRESS 228 ILLINOIS Ave, City | | | | 23c. DATE SIGNED 12-10-54 | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 24b. DATE 12/10/54 | | 24c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery | | 24d. LOCATION (City, town, or county) (State) St. Joseph, Mo | | | |
| DATE REC'D BY LOCAL REG. Dec. 14, 1954 | | REGISTRAR'S SIGNATURE Kathryn M. Allison | | | 25. FUNERAL DIRECTOR'S SIGNATURE (Licensed Embalmer's Statement on Reverse Side) | | ADDRESS St. Joseph, Mo | | |

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

APR 18 1955

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. 392

P. O. Address.....
D. Joseph

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.