

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

9584

State File No.

BIRTH NO. _____ REG. DIST. NO. 166 PRIMARY REG. DIST. NO. 5605 Registrar's No. 13

1. PLACE OF DEATH a. COUNTY <u>Johnson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Pennsylvania</u> b. COUNTY <u>Allegheny</u>	
b. CITY (If outside corporate limits, write RURAL and give town) <u>Rural (WASHINGTON)</u> c. LENGTH OF STAY (in this place) <u>24 hrs.</u>		c. CITY OR TOWN <u>Pittsburgh</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>Knob Noster State Park</u>		STREET ADDRESS (If rural, give location) <u>111-27 Frank Town Road 8370</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>MILAN</u> b. (Middle) <u>SENJAN</u> c. (Last) <u>SENJAN</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>March 16, 1956</u>		
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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>Feb. 15, 1918</u>		9. AGE (In years last birthday) <u>38</u> IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Airman (M/Sgt.)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Air Force</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Pittsburgh, Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
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13a. FATHER'S NAME <u>Stephan Senjan</u>		13b. MOTHER'S MAIDEN NAME <u>Anna Raynovitch</u>		14. NAME OF HUSBAND OR WIFE <u>Lena Velarie</u>	
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Nov. 29, 1949</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Whiteman Air Force Base Records</u>		ADDRESS <u>Sedalia, Missouri</u>	
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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.		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Carbon Monoxide Poisoning</u>				INTERVAL BETWEEN ONSET AND DEATH	
		ANTECEDENT CAUSES Morbid conditions, if any, giving DUE TO (b) 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 <u>9731</u>				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>Suicide</u>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Knob Noster State Park</u>		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>Knob Noster Johnson Missouri</u>	
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>March 16, 1956</u> m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR	
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22. I hereby certify that I ~~viewed~~ viewed the deceased ~~on~~ on 17 March, 1956 at 8:00 PM, 1956, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Kelly Rawlins M.D. Coroner</u>		23b. ADDRESS <u>Holden Mo</u>		23c. DATE SIGNED <u>3/24/56</u>	
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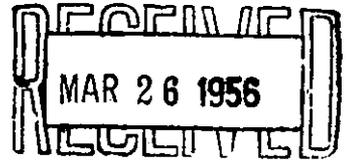
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>3/22/1956</u>		24c. NAME OF CEMETERY OR CREMATORY <u>National Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Ft. Scott, Kansas</u>	
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DATE REC'D BY LOCAL REG. <u>3/24/56</u>		REGISTRAR'S SIGNATURE <u>Erma L. Beatty</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>DW Heckart</u>		ADDRESS <u>Sedalia, Mo.</u>	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

GILLESPIE FUNERAL HOME

141-c



JOHNSON COUNTY HEALTH DEPT.

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. 527 working under my personal supervision..

Student Clifford Gouge Signature of Student Embalmer

Signed DW Heckart

Licensed Embalmer No. 347

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