

9550

 THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

FILED APR 8 - 1957

STATE FILE NUMBER

 Registration District No. 254 Primary Registration District No. 4385 Registrar's No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
a. COUNTY <u>Oregon</u>		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Koshkonong</u>		c. CITY OR TOWN <u>Koshkonong</u>		d. STREET ADDRESS (If outside, give location)	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		Length of stay in 1b <u>14 years</u>		e. STATE <u>Missouri</u>		b. COUNTY <u>Oregon</u>	
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH			
First <u>Charles</u>		Middle <u>Stanley</u>		Last <u>Choinski</u>		Month <u>March</u> Day <u>23</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 17, 1858</u>	9. AGE (In years last birthday) <u>98</u>	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired from Tie & Timber Company</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Milwaukee, Wisconsin</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	Months <u>4</u>	Days <u>6</u>	Hours <u></u> Min. <u></u>
13. FATHER'S NAME <u>Stanislaus Choinski</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>441-10-7734</u>		17. INFORMANT <u>Carrie Choinski, Koshkonong, Missouri</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Bladder</u> DUE TO (b) <u>Smoking</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							INTERVAL BETWEEN ONSET AND DEATH <u>1 yr</u>
20a. ACCIDENT <input type="checkbox"/>		SUICIDE <input type="checkbox"/>		HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>181X</u>	
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. _____							
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/>		NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <u>March 1956</u> to <u>March 23 1957</u> and last saw <u>him</u> alive on <u>March 23 1957</u> . Death occurred at <u>6:30 a.m.</u> on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>Paul O. Wolff M.D.</u>				22b. ADDRESS <u>181X</u>		22c. DATE SIGNED <u>3-30-57</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>3-26-1957</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Koshkonong Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Koshkonong, Missouri</u>	
24. FUNERAL DIRECTOR <u>Edward Curtis - Thru me</u>				25. DATE RECD. BY LOCAL REG. <u>3-30-1957</u>		26. REGISTRAR'S SIGNATURE <u>Arthur Wolff</u>	

(Licensed Embalmer's Statement on Reverse Side)

Health,
Welfare
Public
Service300
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

462

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
Signature of Student Embalmer

Signed *Richard Carter*

Licensed Embalmer No. *451*

P. O. Address *Thayer St*

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.