

Health,  
Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

57-021118  
STATE FILE NUMBER  
2067

FILED JUL 12 1957

Registration District No. 149 Primary Registration District No. 1002 Registrar's No.

300  
1-57

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>New Jersey</b> COUNTY <b>Bergen</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Bayonne</b> 82908 Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Menorah Hospital</b>		Length of stay in 1b <b>6/22/57</b>	d. STREET ADDRESS (If outside, give location) <b>604 Avenue E.</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Michael</b> Middle <b>S.</b> Last <b>Hladik</b>			4. DATE OF DEATH Month <b>June</b> Day <b>26</b> Year <b>1957</b>		
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5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday) <b>20</b>	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) <b>Airman 2nd class</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Airforce</b>	11. BIRTHPLACE (City and state or country) <b>Bayonne New Jersey</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
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13a. FATHER'S NAME <b>George Hladik</b>	13b. MOTHER'S MAIDEN NAME <b>Julia Wattz</b>	14. NAME OF HUSBAND OR WIFE <b>none</b>
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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) <b>in service</b>	16. SOCIAL SECURITY NO. <b>-</b>	17. INFORMANT Address <b>Edward Hladik 604 Ave. E. Bayonne N. J.</b>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Laceration &amp; Midbrain injury</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 Days</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		<b>E8234 31</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT <input checked="" 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.) <b>Automobile Automobile accident</b>
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20c. TIME OF INJURY <b>5:30</b> Hour Month, Day, Year <b>###6/22/57</b>	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Highway</b>	20f. CITY, TOWN, OR LOCATION <b>Bayonne</b> STATE <b>MO.</b>
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21. I attended the deceased from \_\_\_\_\_, to \_\_\_\_\_ and last saw him alive on \_\_\_\_\_  
Death occurred at \_\_\_\_\_ on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <b>Hugh H. Owens</b> (Degree or title)	22b. ADDRESS <b>1034 Pleasant Blvd</b>	22c. DATE SIGNED <b>6-26-57</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>6-26-57</b>	23c. NAME OF CEMETERY OR CREMATORY <b>-</b>	23d. LOCATION (City, town, or county) (State) <b>Bayonne N. J.</b>
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24. FUNERAL DIRECTOR <b>Stine &amp; McClure</b>	ADDRESS <b>K. C. Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>6-26-57</b>	26. REGISTRAR'S SIGNATURE <b>Neva Minshall</b>
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION  
Hugh H. Owens

Director, coroner, etc. must use only standard nomenclature in item 10. No symptoms will be listed. All diseases in Part I must be causally related.



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 *W. J. Nozinger*

Licensed Embalmer No. *5738*

P. O. Address *10 M*

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.