

FILED SEP 3 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER 57 027582

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 931

1. PLACE OF DEATH a. COUNTY <b>Buchanan</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Buchanan</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Joseph</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>St. Joseph,</b>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL <b>St. Joseph Hospital</b>		Length of stay in lb <b>73yrs</b>	d. STREET ADDRESS <b>2527 So 14th</b>
		(If outside, give location)	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Otto</b> Middle <b>W</b> Last <b>Stachorowski</b>			4. DATE OF DEATH Month <b>Aug</b> Day <b>23</b> Year <b>1957</b>		
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5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 20, 1883</b>	9. AGE (In years last birthday) <b>73</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>Re. Laborer</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Packing House</b>	11. BIRTHPLACE (City and state or country) <b>St. Joseph, Mo</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
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13a. FATHER'S NAME <b>?</b>	13b. MOTHER'S MAIDEN NAME <b>?</b>	14. NAME OF HUSBAND OR WIFE <b>Susan Stachorowski</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>no</b>	16. SOCIAL SECURITY NO. <b>none</b>	17. INFORMANT <b>Susan Stachorowski</b> Address <b>St. Joseph, Mo</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>Bronchial Pneumonia</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Unk.</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Arteriosclerotic Heart Disease</b>	<b>Unk.</b>
	DUE TO (c) _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>4200</b>		19. WAS AUTOPSY PERFORMED? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>

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.)
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20c. TIME OF INJURY Hour _____ Month, Day, Year _____ a.m. _____ p.m. _____	20d. INJURY OCCURRED WHILE AT <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 _____
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21. I attended the deceased from <b>8/13/57</b> to <b>8/23/57</b> and last saw him alive on <b>8/22/57</b> Death occurred at <b>3:15</b> P. m on the date stated above; and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE <b>Archie W. Stearns M.D.</b> (Degree or title)	22b. ADDRESS <b>Social Welfare Board 10th &amp; Olive, Patee Hall St. Joseph, Mo.</b>	22c. DATE SIGNED <b>8/24/57</b>
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23a. BURIAL, CREMATION, REINTERMENT (Specify) <b>Burial</b>	23b. DATE <b>8/26/57</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Memorial Park</b>	23d. LOCATION (City, town, or county) (State) <b>St. Joseph, Mo</b>
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24. FUNERAL DIRECTOR <b>John Papp</b> ADDRESS <b>St. Joseph, Mo</b>	25. DATE RECD. BY LOCAL REG. <b>Aug. 30, 1957</b>	26. REGISTRAR'S SIGNATURE <b>Mrs. Robert Fulton</b>
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

OCT 17 1956

DEC 16 1957

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, ~~and~~ ....., Student Embalmer No. ....  
working under my personal supervision.

Student .....  
Signature of Student Embalmer

Signed *Joseph* .....

Licensed Embalmer No. *3986*  
P. O. Address *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.