

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-000352

STATE FILE NUMBER

38

Registration District No. 042 Primary Registration District No. 1000 Registrar's No.

FILED JAN 19 1959

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| 1. PLACE OF DEATH a. COUNTY Buchanan | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Buchanan | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN St. Joseph 1170 |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Joseph's Hosp. | | Length of stay in 1b 48 Yrs | d. STREET ADDRESS (If outside, give location) 726 South 23rd |
| | | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

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| 3. NAME OF DECEASED (Type or print) First Middle Last CATHERINE SOLTYS | 4. DATE OF DEATH Month Day Year January 10, 1959 |
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| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Aug. 26, 1898 | 9. AGE (In years last birthday) 60 | 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) Housewife | 10b. KIND OF BUSINESS OR INDUSTRY At home | 11. BIRTHPLACE (City and state or country) New York | 12. CITIZEN OF WHAT COUNTRY? USA |
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| 13a. FATHER'S NAME Frank Rakowski | 13b. MOTHER'S MAIDEN NAME Dorothy Unknown | 14. NAME OF HUSBAND OR WIFE Stanley J. Soltys |
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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) No | 16. SOCIAL SECURITY NO. None | 17. INFORMANT Stanley J. Soltys | Address 726 So. 23rd | City City |
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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) <u>Congestive heart failure</u> | | INTERVAL BETWEEN ONSET AND DEATH 1957 |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | DUE TO (b) <u>Hypertensive heart disease</u> | |
| | DUE TO (c) <u>Arterial hypertension</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>443X</u> | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |

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| 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. | 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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| 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 |
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21. I attended the deceased from 12-26-55 to 1-10-59 and last saw her alive on 1-10-59
Death occurred at 12:55P m on the date stated above; and to the best of my knowledge, from the causes stated.

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| 22a. SIGNATURE (Degree or title) <u>J. P. Chiarotino, M.D.</u> | 22b. ADDRESS <u>Mrs. Bldg. 13th + Tenth</u> | 22c. DATE SIGNED <u>1-12-59</u> |
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| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE Jan. 13, 59 | 23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery | 23d. LOCATION (City, town, or county) (State) St. Joseph, Mo. |
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| 24. FUNERAL DIRECTOR <u>H. D. Sidenfaden & Son</u> R.R. 9. | ADDRESS <u>St. Joseph, Mo.</u> | 25. DATE REC'D. BY LOCAL REG. <u>Jan. 12, 1959</u> | 26. REGISTRAR'S SIGNATURE <u>Mr. Clark Goodell</u> |
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All diseases in Part I must be causally related.
 Dr. J. P. Chiarotino
 USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
 MEDICAL CERTIFICATION

Dr Chiarottino

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 Robert H. Gape

Licensed Embalmer No. 3308

P. O. Address St. Joseph, 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.