

Health,  
Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-001386

STATE FILE NUMBER  
224

JAN 28 1959

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

300  
-57

1. PLACE OF DEATH a. COUNTY JACKSON		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE KANSAS b. COUNTY WYANDOTT	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN VA HOSPITAL, K.C., MO.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN KANSAS CITY 8150 Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION VA HOSPITAL		Length of stay in 1b 14 days	d. STREET ADDRESS (If outside, give location) 2507 ORVILLE Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First JOSEPH Middle JACOB Last KUCEJ			4. DATE OF DEATH Month JANUARY Day 11, Year 1959		
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5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 12-23-94	9. AGE (In years last birthday) 64	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) Maint. Utilities, Retired	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Austria-Hungary	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME JOHN KUCEJ	13b. MOTHER'S MAIDEN NAME EVE SMALS	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, name unknown) (If yes, give what date of service) YES WW I	16. SOCIAL SECURITY NO. 335 07 1933	17. INFORMANT Address Official Records VA Hospital, K.C., Mo.
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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>Bronchopneumonia</u>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) _____ DUE TO (c) <u>Bronchial carcinoma, R.U.L.</u>	
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 checked="" type="checkbox"/> NO <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 WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) VA	20f. CITY, TOWN, OR LOCATION COUNTY STATE
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21. attended the deceased from Death occurred at <u>Dec 22, 1958</u> to <u>Jan 11, 1959</u> <u>3:50</u> P. m on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE J. A. TURNER, (M.D. or title) <i>J.A. Turner</i>	22b. ADDRESS VA Hospital, K.C., Mo.	22c. DATE SIGNED 1-12-59
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23a. MANNER OF BURIAL, CREMATION, or REMOVAL (Specify) Burial	23b. DATE 1-15-1959	23c. NAME OF CEMETERY OR CREMATORY Mt. Calvary	23d. LOCATION (City, town, or county) (State) Kansas City, Kansas
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24. FUNERAL DIRECTOR Skradski - Stine F. H. Matt Skradski	ADDRESS K. C. K.	25. DATE RECD. BY LOCAL REG. 1-13-59	26. REGISTRAR'S SIGNATURE <i>Steve Marshall</i>
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *Mark Shradick* .....

..... Licensed Embalmer No. *4382*  
..... P. O. Address *R. Q. No.* .....

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.