

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-008518

STATE FILE NUMBER

308

FILED MAR 30 1959

Registration District No.

042

Primary Registration District No.

1000

Registrar's No.

300

1-57

3

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Dr. Martin H. Christ

ALL diseases in Part I must be causally related.

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY Buchanan	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph		c. CITY OR TOWN St. Joseph, 0117	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 15 Alabama		d. STREET ADDRESS (If outside, give location) 6411 Washington	
3. NAME OF DECEASED (Type or print) First Middle Last (Katie) Catherine Sokolaski		4. DATE OF DEATH Month Day Year March 23, 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 25, 1884
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bo Laborer		10b. KIND OF BUSINESS OR INDUSTRY Packing House	11. BIRTHPLACE (City and state or country) Poland
13a. FATHER'S NAME John Jagodzinski		13b. MOTHER'S MAIDEN NAME Mary Skazinski	14. NAME OF HUSBAND OR WIFE deceased
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no no		16. SOCIAL SECURITY NO. 4201	17. INFORMANT Address Clara Malota St. Joseph, Mo
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Arteriosclerotic Heart Disease DUE TO (c) Hypertension PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Pernicious Anemia			INTERVAL BETWEEN ONSET AND DEATH Immediate unk unk
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.)	
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.)	
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from 7:26 2 1959 to Mar 23, 1959 and last saw her alive on Mar. 23, 1959 Death occurred at 11:00 P. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Martin H. Christ M.D.		22b. ADDRESS 6106 Key Hill Ave	
22c. DATE SIGNED Mar 24, 1959			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3 25/59	
23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		23d. LOCATION (City, town, or county) (State) St. Joseph, Mo	
24. FUNERAL DIRECTOR John Rupp		25. DATE RECD. BY LOCAL REG. Mar. 26, 1959	
ADDRESS St. Joseph, Mo		26. REGISTRAR'S SIGNATURE Mrs. Clark Randall	

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 *John E. Rupp*
Licensed Embalmer No. *3986*

P. O. Address *St. 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.