

Health, Welfare and Public Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-009492
STATE FILE NUMBER
1426

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1426

300
-57

1. PLACE OF DEATH a. COUNTY <i>Jackson</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Missouri</i> b. COUNTY <i>Jackson</i>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <i>Kansas City</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <i>Independence</i> 7805 Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OR HOSPITAL OR INSTITUTION <i>St Lukes W.O.A. work day</i>		Length of stay in 1b <i>work day</i>	d. STREET ADDRESS (If outside, give location) <i>2315 S. Harvard</i> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <i>Karlis</i> Middle <i>A.</i> Last <i>Kaminski</i>			4. DATE OF DEATH Month <i>Mar</i> - Day <i>16</i> - Year <i>1959</i>		
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5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>aug-18-1905</i>	9. AGE (In years last birthday) <i>54</i>	IF UNDER 1 YEAR Months <i>5</i> Days <i>5</i>	IF UNDER 24 HRS. Hours <i>5</i> Min. <i>5</i>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>truck driver</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Concrete Co</i>	11. BIRTH PLACE (City and state or country) <i>Madona Latvia</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
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13a. FATHER'S NAME <i>Karlis Kaminski</i>	13b. MOTHER'S MAIDEN NAME <i>unknown</i>	14. NAME OF HUSBAND OR WIFE <i>Irene Kaminski</i>
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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) <i>no</i>	16. SOCIAL SECURITY NO. <i>725-12-1552</i>	17. INFORMANT <i>Irene Kaminski</i> Address <i>Indep. Mo</i>
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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) <i>Shock - Remedy results from crushing injuries of chest, gas, multiple rib fractures and ruptured lungs</i>		INTERVAL BETWEEN ONSET AND DEATH <i>8300</i>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (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)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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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.) <i>was crushed between two trucks</i>
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20c. TIME OF INJURY Hour <i>3</i> Month <i>16</i> Day <i>59</i> Year <i>59</i> a.m. p.m.	20d. INJURY OCCURRED WHILE AT WORK <input checked="" 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.) <i>Factory</i>	20f. CITY, TOWN, OR LOCATION <i>Independence, Mo</i>	COUNTY <i>Jackson</i>	STATE <i>Mo</i>
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21. I attended the deceased from _____ to _____ and last saw her alive on _____ Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE <i>Ronald R. Speaks</i> (Degree or title) <i>3</i>	22b. ADDRESS <i>6625 Market St</i>	22c. DATE SIGNED <i>3-17-59</i>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Buried</i>	23b. DATE <i>Mar-19-59</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Mount Washington</i>	23d. LOCATION (City, town, or county) (State) <i>Independence, Mo</i>
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24. FUNERAL DIRECTOR <i>Ronald R. Speaks</i> ADDRESS <i>Indep</i>	25. DATE RECD. BY LOCAL REG. <i>3-18-59</i>	26. REGISTRAR'S SIGNATURE <i>new Marshall</i>
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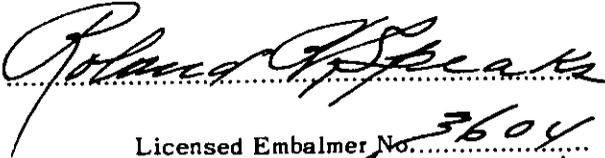
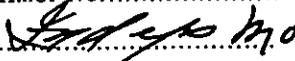
(Licensed Embalmers' Statement on Reverse Side)

Ge. C. Keahlofer, M.D. MEDICAL CERTIFICATION USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE. 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 
Licensed Embalmer No. 3604
P. O. Address. 

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.