

DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-024809

FILED VS AUG 3 1959

Registration District No. 1228 Primary Registration District No. 2000 Registrar's No. 789

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY GREENE				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE COUNTY PENNSYLVANIA ALLEGEHNY									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN SPRINGFIELD		Length of stay in 1b 1 DAY		c. CITY OR TOWN PITTSBURG		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION D.O.A. ST. JOHN'S			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 302 KNOEDLER ROAD		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First Middle Last JOHN SAPACHAK				4. DATE OF DEATH Month Day Year JULY 23 1959									
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 7/26/1907		9. AGE (last birthday) 51		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HR	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CONSTRUCTION			10b. KIND OF BUSINESS OR INDUSTRY LABOR			11. BIRTHPLACE (City and state or country) PITTSBURGH, PA.			12. CITIZEN OF WHAT COUNTRY U S A				
13a. FATHER'S NAME CHARLES SAPACHAK			13b. MOTHER'S MAIDEN NAME ANNA NENUS			14. NAME OF HUSBAND OR WIFE DIVORCED							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES WWII			16. SOCIAL SECURITY NO. 172-09-7395			17. INFORMANT Address MRS. C.E. BRADEL PITTSBURG, PA.							
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>Likely Myocardial insufficiency</i> DUE TO (b) <i>Likely Coronary sclerosis</i> DUE TO (c) UNATTENDED BY A PHYSICIAN Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.								INTERVAL BETWEEN ONSET AND DEATH <i>Unknown</i>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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.)									
20c. TIME OF INJURY Hour a.m. p.m.		Month, Day, Year											
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				
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____. Death occurred at APPROX. 5 PM on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE (Degree or title) <i>James R. Amos M.D.</i>				22b. ADDRESS Greene County Health Officer Court House, Springfield, Missouri				22c. DATE SIGNED 7-27-59					
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		23b. DATE 7/24/1959		23c. NAME OF CEMETERY OR CREMATORY UNKNOWN		23d. LOCATION (City, town, or county) PITTSBURG, PENN.							
24. FUNERAL DIRECTOR ADDRESS HERMAN LOHMEYER'S SPRINGFIELD, MO.				25. DATE RECD. BY LOCAL REG. 7-27-59		26. REGISTRAR'S SIGNATURE <i>Effie B. Melton</i>							

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATE OF TEXAS DEPARTMENT OF HEALTH

FORM

EXPIRES
AUG 21 1985

DATE OF ISSUE

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed H J Mc Cam

Licensed Embalmer No. 272

P. O. Address Springfield

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.