

# FURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

# 59-037186

FILED VS. NOV 3 1959

290

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

124

STATE FILE NUMBER

INDEXED

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Pulaski</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Near Buckhorn</u> Length of stay in lb _____ c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>5 Mi. W. Waynesville Highway 66</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Ohio</u> b. COUNTY <u>Summit</u> c. CITY OR TOWN <u>Akron</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>1850 E. 14th St.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
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<b>3. NAME OF DECEASED</b> (Type or print) First <u>Karl</u> Middle <u>---</u> Last <u>Duenk</u>			<b>4. DATE OF DEATH</b> Month <u>Oct</u> Day <u>15</u> Year <u>59</u>		
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<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>Cau</u>	<b>7. Married</b> <input type="checkbox"/> <b>Never Married</b> <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>8 May 33</u>	<b>9. AGE (last birthday)</b> <u>26</u>	<b>IF UNDER 1 YEAR</b> Months _____ Days _____	<b>IF UNDER 24 HR</b> Hours _____ Min. _____
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<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Soldier</u>	<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>US Army</u>	<b>11. BIRTHPLACE</b> (City and state or country) <u>Yugoslavia</u>	<b>12. CITIZEN OF WHAT COUNTRY</b> <u>Yugoslavia</u>
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<b>13a. FATHER'S NAME</b> <u>Deceased</u>	<b>13b. MOTHER'S MAIDEN NAME</b> <u>Luzia (Unknown)</u>	<b>14. NAME OF HUSBAND OR WIFE</b> _____
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<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes 19 May 58 to present 372-36-0730</u>	<b>16. SOCIAL SECURITY NO.</b> <u>372-36-0730</u>	<b>17. INFORMANT</b> Address <u>R.E. Stivers Ft Leonard Wood, Mo</u>
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<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Subarachnoid hemorrhage</u> DUE TO (b) <u>Basilar skull fracture</u> DUE TO (c) <u>Auto accident</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	INTERVAL BETWEEN ONSET AND DEATH _____
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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
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<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	<b>20a. ACCIDENT</b> <input checked="" type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.) <u>Auto accident</u>
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<b>20c. TIME OF INJURY</b> Hour <u>11:30</u> Month, Day, Year <u>10-14-59</u>	<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>
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<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Highway</u>	<b>20f. CITY, TOWN, OR LOCATION</b> <u>Buckhorn</u>	<b>COUNTY</b> <u>Pulaski</u>	<b>STATE</b> <u>Mo</u>
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<b>21. Death occurred at</b> <u>12:40</u> <b>on</b> <u>15 Oct 59</u> <b>to</b> _____ <b>at</b> _____	Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated.
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<b>22a. SIGNATURE</b> (Degree or title) <u>Hans H. Baruch, Capt, MC</u>	<b>22b. ADDRESS</b> <u>US Army Hospital Ft Leonard Wood, Mo</u>	<b>22c. DATE SIGNED</b> <u>15 Oct 59</u>
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<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>burial</u>	<b>23b. DATE</b> <u>Unknown</u>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>unknown</u>	<b>23d. LOCATION</b> (City, town, or county) (State) <u>EUROPE</u>
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<b>24. FUNERAL DIRECTOR</b> ADDRESS <u>T.J. Shadel, Lebanon, Mo.</u>	<b>25. DATE RECD. BY LOCAL REG.</b> <u>10-20-59</u>	<b>26. REGISTRAR'S SIGNATURE</b> <u>Paula M. Anderson</u>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

3561 62 I ADON ST

**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 Warrin O. Simpson

Licensed Embalmer No. 5071

P. O. Address Houston, Texas

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.