

R.I. DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-004141

FILED VS FEB 5 1960

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. **2 809** STATE FILE NUMBER

|  |   |   |  |   |  |  |  |
|--|---|---|--|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY   |   |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Iowa</b> b. COUNTY |  |  |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR<br>TOWN <b>St. Louis</b>   |   | Length of stay in 1b  |  | c. CITY OR TOWN <b>Keokuk</b>   |  | Inside Limits<br>Yes <input type="checkbox"/> No <input type="checkbox"/>  |  |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>DePaul Hospital</b>  |   |   | Inside Limits<br>Yes <input type="checkbox"/> No <input type="checkbox"/>                |   | d. STREET ADDRESS (If outside, give location)<br><b>unknown</b>      |  | Reside on Farm<br>Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <b>John</b> Middle <b>Szabluk</b> Last   |   |   |  | 4. DATE OF DEATH<br>Month <b>January</b> Day <b>22</b> Year <b>1960</b>   |  |  |  |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b>  | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>9/19/1912</b>  | 9. AGE (last birthday)<br><b>47</b>                                  | IF UNDER 1 YEAR<br>Months <b>4</b> Days <b>3</b>   | IF UNDER 24 HR<br>Hours <b>3</b> Min.                                      |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Maintenance man</b>  |   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Keokuk Hospital</b>                              |   | 11. BIRTHPLACE (City and state or country)<br><b>Poland</b>          |  | 12. CITIZEN OF WHAT COUNTRY<br><b>Poland</b>                               |
| 13a. FATHER'S NAME<br><b>Wesil Szabluk</b>   |   |   | 13b. MOTHER'S MAIDEN NAME<br><b>Maria Lisak</b>  |   |  | 14. NAME OF HUSBAND OR WIFE<br><b>Janina Szabluk</b>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown); (If yes, give war or dates of service)<br><b>no</b>  |   | 16. SOCIAL SECURITY NO.<br><b>182-38-8023</b>   |  | 17. INFORMANT<br><b>Janina Szabluk Keokuk Iowa</b><br>Address   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Chr. meningitis, Bright's disease</b>   |   |   |  |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>3 years</b>   |  |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.<br>DUE TO (b) <b>592x</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)<br><b>Diabetes mellitus</b>  |   |   |  |   |  | PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |  |
| 19. WAS AUTOPSY PERFORMED?<br>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<br>Hour _____ a.m. _____ p.m.<br>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<br><b>Keokuk, Iowa</b>                  |  | STATE  |
| 21. I attended the deceased from <b>Nov 22, 1959</b> to <b>Jan 22, 1960</b> and last saw her/him alive on <b>Jan 21, 1960</b><br>-Death occurred at <b>11:00 P.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated. |   |   |  |   |  |  |  |
| 22a. SIGNATURE<br><b>Wayne G. Gork M.D.</b> (Degree or title)  |   |   |  | 22b. ADDRESS<br><b>100 N. Euclid</b>  |  | 22c. DATE SIGNED<br><b>1-22-60</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Removal Mortal</b>   |   | 23b. DATE<br><b>Jan 22 1960</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>City Cemetery</b>                               |   | 23d. LOCATION (City, town, or county)<br><b>Keokuk, Iowa</b> (State) |  |  |
| 24. FUNERAL DIRECTOR<br><b>Greaves Funeral Home Keokuk Iowa</b> ADDRESS  |   |   |  | 25. DATE RECD. BY LOCAL REG.<br><b>JAN 23 1960</b>  |  | 26. REGISTRAR'S SIGNATURE<br><b>Earl Smith. M.D.</b>   |  |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**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 Arnold W. Schoen

Licensed Embalmer No. 3864

P. O. Address St. Louis,

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.