

MURKIN DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-005245

FILED VS. FEB 29 1960 042

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STATE FILE NUMBER

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

1. PLACE OF DEATH a. COUNTY <i>Buchanan</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Mo</i> b. COUNTY <i>Buchanan</i>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>St. Joseph</i>		Length of stay in lb <i>57 Yrs</i>	c. CITY OR TOWN <i>St. Joseph</i> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>St. Joseph Hosp.</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <i>605 Alabama</i> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <i>Mary</i> Middle _____ Last <i>Nurski</i>	4. DATE OF DEATH Month <i>Feb.</i> Day <i>10,</i> Year <i>1960</i>
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5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <i>Jan. 28, 1888</i>	9. AGE (last birthday) <i>72</i>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housekeeper</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	11. BIRTHPLACE (City and state or country) <i>Poland</i>	12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>
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13a. FATHER'S NAME <i>John Proc</i>	13b. MOTHER'S MAIDEN NAME <i>Pellagia ?</i>	14. NAME OF HUSBAND OR WIFE <i>George Nurski (de)</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>none</i>	17. INFORMANT <i>Carl Nurski, St. Joseph, 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>Acute Cardiac Decompensation</i>		INTERVAL BETWEEN ONSET AND DEATH <i>36 hrs</i>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <i>Coronary Heart Disease</i>	<i>4 yrs</i>
	DUE TO (c) <i>Arteriosclerotic Heart Disease</i>	<i>4 yrs</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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
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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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____
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20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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 _____
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21. I attended the deceased from *6/20/1956* to *2/10/60* and last saw <sup>her</sup> <sub>him</sub> alive on *2/10/60*  
Death occurred at *1:20 P.M.* on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <i>Sharon E. Weggoner M.D.</i>	22b. ADDRESS <i>301 Illinois Ave St. Joseph, Missouri</i>	22c. DATE SIGNED <i>2/13/60</i>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>2/13/60</i>	23c. NAME OF CEMETERY OR CREMATORY <i>St. Olivet Cemetery</i>	23d. LOCATION (City, town, or county) (State) <i>St. Joseph, Mo</i>
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24. FUNERAL DIRECTOR <i>John E. Kupp</i>	ADDRESS <i>St. Joseph</i>	25. DATE RECD. BY LOCAL REG. <i>Feb. 19, 1960</i>	26. REGISTRAR'S SIGNATURE <i>Wm. Clark Goodell</i>
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(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

BY AFFIDAVIT OF S.E. Weggoner, M.D. MEDICAL CERTIFICATION

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by

celey \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed

John E. Kupka

Licensed Embalmer No. 3986

P. O. Address A. Joseph

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.