

FEDERAL BUREAU OF INVESTIGATION
DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-033867

FILED VS SEP 19 1960

042

Primary Registration District No. 1000

Registrar's No. 947

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY Buchanan b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph Length of stay in 1b 72 Yrs c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION 822 Warsaw St. Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Buchanan c. CITY OR TOWN St. Joseph Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) 822 Warsaw St. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First MARTH A Middle Last DOMANSKI			4. DATE OF DEATH Month September Day 9, Year 1960		
5. SEX Female	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 1/14/1878	9. AGE (last birthday) 82 IF UNDER 1 YEAR Months Days IF UNDER 24 HR Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home	11. BIRTHPLACE (City and state or country) Poland	12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME Leon Pyszora		13b. MOTHER'S MAIDEN NAME Anna Fisher		14. NAME OF HUSBAND OR WIFE Anthony Domanski	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	17. INFORMANT Address Julia Wawrzyniak 822 Warsaw City		
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>Intra abdominal malignancy - Intestinal Hemorrhage.</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) _____ 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					INTERVAL BETWEEN ONSET AND DEATH Not Known
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 9-8-60 to 9-9-60 and last saw her alive on 9-8-60 Death occurred at 5:00 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <i>Robert W. Kieber, MD</i>		22b. ADDRESS St Joseph, Mo		22c. DATE SIGNED 9-9-60	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Sept. 12, 1960	23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		23d. LOCATION (City, town, or county) (State) St. Joseph, Mo.	
24. FUNERAL DIRECTOR ADDRESS H.O. Szymanski & Son St. Joseph, Mo. R.P.Y.		25. DATE RECD. BY LOCAL REG. Sept. 10, 1960	26. REGISTRAR'S SIGNATURE Wm. Clark Goodell		

DOCUMENT

R.W. Kieber, M.D.

BY AFFIDAVIT OF

Dr. Kieffer

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 *Robert G. Gable*

Licensed Embalmer No. 3308

P. O. Address St. Joseph, Mo.

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.