

FRI. DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS JAN 3 1961 042

-60-045177
STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. 1000 Registrar's No. 1347

INDEXED

1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Buchanan</u>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Joseph</u>		Length of stay in 1b <u>life</u>		c. CITY OR TOWN <u>St. Joseph</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>813 S. 17th St.</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>813 S. 17th St.</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>LUCY</u> Middle <u>J.</u> Last <u>CHOJNOWSKI</u>				4. DATE OF DEATH Month <u>December</u> Day <u>25</u> Year <u>1960</u>					
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>7/11/1892</u>	9. AGE (last birthday) <u>68</u>	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) <u>housework</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (City and state or country) <u>St. Joseph, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>		
13a. FATHER'S NAME <u>Peter P. Chojnowski</u>			13b. MOTHER'S MAIDEN NAME <u>Josephine Bunkowski</u>			14. NAME OF HUSBAND OR WIFE			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>			16. SOCIAL SECURITY NO. <u>492-38-5568</u>		17. INFORMANT Address <u>Julia Chojnowski, 813 S. 17th, St. Joseph, Mo.</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Carcinoma of uterus (FUNDUS)</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>8 mo</u> <u>15 mo</u>		
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 <u>1959</u> to <u>12-25-60</u> and last saw her <u>12-24-60</u> alive on Death occurred at <u>10:10 a.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) <u>Clement C Chojnowski MD</u>				22b. ADDRESS <u>St. Joseph Mo</u>				22c. DATE SIGNED <u>12-28-60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE <u>12/28/1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>			23d. LOCATION (City, town, or county) (State) <u>St. Joseph Mo.</u>			
24. FUNERAL DIRECTOR ADDRESS <u>Heaton-Bowman, St. Joseph, Mo.</u>			25. DATE RECD. BY LOCAL REG. <u>Dec. 30, 1960</u>		26. REGISTRAR'S SIGNATURE <u>Mrs. Clark Goodell</u>				

DOCUMENT

C.C. DuMont, M.D. MEDICAL CERTIFICATION

BY AFFIDAVIT OF

JAN 12 1967

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 Eugene Wood

Licensed Embalmer No. 3804

P. O. Address 314 5010th St.

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.