

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-61-012700  
STATE FILE NUMBER

AMENDED

Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 468

FILED MAY 15 1961

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY Buchanan		a. STATE Mo b. COUNTY Buchanan	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph		c. CITY OR TOWN St. Joseph	
Length of stay in lb 50yrs		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Joseph Hosp		d. STREET ADDRESS (If outside, give location) 3009 So 29th	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH
First Middle Last Frank Krawczyk			Month Day Year May 7, 1961
5. SEX Male	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 Dec 12 1902
9. AGE (last birthday) 58		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) Re. Electrician		10b. KIND OF BUSINESS OR INDUSTRY Electric Co	11. BIRTHPLACE (City and state or country) Poland
12. CITIZEN OF WHAT COUNTRY U.S.A.		13a. FATHER'S NAME Michael Krawczyk	
13b. MOTHER'S MAIDEN NAME Caroline Skurka		14. NAME OF HUSBAND OR WIFE Mary Krawczyk	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		17. INFORMANT Address Mary Krawczyk St. Joseph, Mo	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:			INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <i>Cerebral Vascular accident</i>			3 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <i>Hypertension</i>			1 1/2
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 checked="" 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 <i>4-4-61</i> to <i>4/7/61</i> and last saw him alive on <i>4-7-61</i> Death occurred at <i>12:25 P.M.</i> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Decease or title) <i>Demetrius C. Simpson M.D.</i>		22b. ADDRESS <i>St. Joseph, Mo</i>	22c. DATE SIGNED <i>5-9-61</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>5/10/61</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Olivet Cemetery</i>	23d. LOCATION (City, town, or county) <i>St. Joseph, Mo</i>
24. FUNERAL DIRECTOR <i>John E. [Signature]</i>	ADDRESS <i>St. Joseph, Mo</i>	25. DATE RECD. BY LOCAL REG. <i>May 10, 1961</i>	26. REGISTRAR'S SIGNATURE <i>Thos. Clark Goodell</i>

DATE AMENDED

INSTEAD OF DOCUMENT

ITEM NO. SHOULD READ

DOCUMENT

BY AFFIDAVIT OF (C.C. Day Mont, M.D.) MEDICAL CERTIFICATION

