

SOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-025186

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

2943

STATE FILE NUMBER

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. _____

FILED JUL 20 1961

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| 1. PLACE OF DEATH | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) | |
| a. COUNTY Jackson | | a. STATE Missouri COUNTY Jackson | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City | | c. CITY OR TOWN Kansas City | |
| Length of stay in 1b Life | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION 100 1/2 Askew | | d. STREET ADDRESS (If outside, give location) 535 Newton | |
| Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |

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| 3. NAME OF DECEASED (Type or print) | | | 4. DATE OF DEATH | |
| First WALTER Middle _____ Last GRAZDA | | | Month June Day 12 Year 1961 | |

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|-----------------------|----------------------------------|---|------------------------------------|-------------------------------------|--|--|
| 5. SEX Male | 6. COLOR OR RACE White | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/> | 8. DATE OF BIRTH 2/25/24 | 9. AGE (last birthday) 36 | 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) Laborer | 10b. KIND OF BUSINESS OR INDUSTRY Iron Worker | 11. BIRTHPLACE (City and state or country) Kansas City Mo | 12. CITIZEN OF WHAT COUNTRY USA |
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|--|--|--------------------------------------|
| 13a. FATHER'S NAME John Grazda | 13b. MOTHER'S MAIDEN NAME Frances Gronneck | 14. NAME OF HUSBAND OR WIFE _____ |
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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) Yes W W 2 | 17. INFORMANT Address Mike Grazda 3213 Indep Ave K C Mo |
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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: | | INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) Overdosing of Barbiturate poison | | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | DUE TO (b) _____ DUE TO (c) _____ | |

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| 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 |
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| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input checked="" type="checkbox"/> HOMICIDE <input type="checkbox"/> | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) Barbiturate poison |
| 20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year 6-12-61 | | |

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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.) 100 1/2 Askew | 20f. CITY, TOWN, OR LOCATION COUNTY STATE Kansas City Jackson mo |
| 21. I attended the deceased from _____ to _____ and last saw him/her alive on _____ Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated. | | |

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| 22a. SIGNATURE (Degree or title) Geo. C. Kea Thorer | 22b. ADDRESS 6627 West 1st St | 22c. DATE SIGNED 6-13-61 |
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|--|-----------------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE 6/15/61 | 23c. NAME OF CEMETERY OR CREMATORY Mt Olivet Cemetery | 23d. LOCATION (City, town, or county) (State) Kansas City Missouri |
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| 24. FUNERAL DIRECTOR ADDRESS Sheil Funeral Home Kansas City Mo | 25. DATE RECD. BY LOCAL REG. 6-13-61 | 26. REGISTRAR'S SIGNATURE Ruth N. Long |
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(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED

INSTEAD OF

DOCUMENT

ITEM NO. SHOULD READ

BY AFFIDAVIT OF Geo. C. Kea Thorer MEDICAL CERTIFICATION

Faint, mostly illegible text at the top of the page, possibly containing identification or header information.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me
or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Richard E. Carroll

Licensed Embalmer No. 4829

P. O. Address R E M

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.