DEPARTMENT OF PUBLIC HEALTH AND WELFARE — MISSOURI DIVISION OF HEALTH
(PHYSICIAN OR CORONER)

CERTIFICATE OF DEATH

STATE FILE NUMBER 124 73 024102

FILED OCT 29 1973

Registration District No. 316 Primary Registration District No. 6044 Registrar's No. 516

DO NOT WRITE ON THIS STUB

VS 300
Rev. 11/72

7b-c.
7d. 10001
8. 17
14a. 29
14b. 187
14c-d. 11352
14e. 035
23. 0020293
26a. 2
18-U 4109
18-S-1.
18-S-2.
20a-f.
20g-St.
20g-Co.
20g-Cy.

Type or print in PERMANENT BLACK INK. See handbook for instructions.

DECEASED

1. DECEASED—NAME: FRANCIS ANDREW TIMKO
2. SEX: Male
3. DATE OF DEATH (MONTH, DAY, YEAR): October 18, 1973
4. RACE WHITE, NEGRO, AMERICAN INDIAN, ETC. (SPECIFY): White
5a. AGE—LAST BIRTHDAY (YEARS): 58
5b. UNDER 1 YEAR: MOS. / DAYS
5c. UNDER 1 DAY: HOURS / MIN.
6. DATE OF BIRTH (MONTH, DAY, YEAR): Nov 18, 1914
7a. COUNTY OF DEATH: St. Francois
7b. CITY, TOWN, OR LOCATION OF DEATH: Desloge
7c. INSIDE CITY LIMITS (SPECIFY YES OR NO): No
7d. HOSPITAL OR OTHER INSTITUTION—NAME (IF NOT IN EITHER, GIVE STREET AND NUMBER): Star Route
8. STATE OF BIRTH (IF NOT IN U.S.A., NAME COUNTRY): Illinois
9. CITIZEN OF WHAT COUNTRY: U.S.A.
10. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (SPECIFY): Married
11. SURVIVING SPOUSE (IF WIFE, GIVE MAIDEN NAME): Katie Pasternak
12. SOCIAL SECURITY NUMBER: 498-07-6436
13a. USUAL OCCUPATION (GIVE KIND OF WORK DONE DURING MOST OF WORKING LIFE, EVEN IF RETIRED): Miner
13b. KIND OF BUSINESS OR INDUSTRY: Lead Industry

USUAL RESIDENCE WHERE DECEASED LIVED. IF DEATH OCCURRED IN INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION.

14a. RESIDENCE—STATE: Mo.
14b. COUNTY: St. Fran
14c. CITY, TOWN, OR LOCATION, ZIP CODE: Desloge 63601
14d. INSIDE CITY LIMITS (SPECIFY YES OR NO): no
14e. TOWNSHIP: Randolph
14f. STREET AND NUMBER: Star Route, Box 7

PARENTS

15. FATHER—NAME: John M. Timko
16. MOTHER—MAIDEN NAME: Anna Barbara Vargo

17a. INFORMANT—NAME: Mrs. Katie Timko (Wife)
17b. MAILING ADDRESS (STREET OR R.F.D. NO., CITY OR TOWN, STATE, ZIP): Star Route, Box 7; Desloge, Mo. 63601

CAUSE

PART I. DEATH WAS CAUSED BY: [ENTER ONLY ONE CAUSE PER LINE FOR (a), (b), AND (c)]

18. IMMEDIATE CAUSE (a): Acute Myocardial Infarction — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 h
DUE TO, OR AS A CONSEQUENCE OF: (b)
CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST
DUE TO, OR AS A CONSEQUENCE OF: (c)

PART II. OTHER SIGNIFICANT CONDITIONS: CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO CAUSE GIVEN IN PART I (a)

19a. AUTOPSY (YES OR NO): no
19b. IF YES WERE FINDINGS CONSIDERED IN DETERMINING CAUSE OF DEATH

20a. ACCIDENT, SUICIDE, HOMICIDE, OR UNDETERMINED (SPECIFY):
20b. DATE OF INJURY (MONTH, DAY, YEAR):
20c. HOUR:
20d. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN PART I OR PART II, ITEM 18):
20e. INJURY AT WORK (SPECIFY YES OR NO):
20f. PLACE OF INJURY AT HOME, FARM, STREET, FACTORY, OFFICE BLDG., ETC. (SPECIFY):
20g. LOCATION (STREET OR R.F.D. NO., CITY OR TOWN, STATE):
20h. IF DECEASED WAS FEMALE WAS THERE A PREGNANCY IN LAST 90 DAYS: ☐ YES ☐ NO ☐ UNK.

CERTIFIER

21a. CERTIFICATION—PHYSICIAN: I ATTENDED THE DECEASED FROM (MONTH, DAY, YEAR): July 17 73
21b. TO (MONTH, DAY, YEAR): Oct 18 73
21c. AND LAST SAW HIM/HER ALIVE ON (MONTH, DAY, YEAR): Sept 30
21d. I DID/DID NOT VIEW THE BODY AFTER DEATH.
21e. DEATH OCCURRED (HOUR): 12:35 A.M.
AT THE PLACE, ON THE DATE, AND, TO THE BEST OF MY KNOWLEDGE, DUE TO THE CAUSE(S) STATED.

22a. CERTIFICATION—MEDICAL EXAMINER OR CORONER: ON THE BASIS OF THE EXAMINATION OF THE BODY AND/OR THE INVESTIGATION, IN MY OPINION, DEATH OCCURRED ON THE DATE AND DUE TO THE CAUSE(S) STATED.
HOUR OF DEATH: M.
22b. THE DECEDENT WAS PRONOUNCED DEAD (MONTH, DAY, YEAR, HOUR): M.

23a. CERTIFIER—NAME (TYPE OR PRINT): C. H. Appleberry M.D.
23b. MO. LICENSE NO.: 20293
23c. SIGNATURE: C H Appleberry MD
DEGREE OR TITLE:
23d. DATE SIGNED (MONTH, DAY, YEAR): 10-23-73
23e. MAILING ADDRESS—CERTIFIER: 43 St. Joe
STREET OR R.F.D. NO.:
CITY OR TOWN: Riverwines, Mo.
STATE: 63601 ZIP

BURIAL

24a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
24b. CEMETERY OR CREMATORY—NAME: Immaculate Conception Cem, near Desloge, Mo.
LOCATION—CITY OR TOWN, STATE:
24d. DATE (MONTH, DAY, YEAR): Oct 20, 1973
25a. FUNERAL HOME—NAME AND ADDRESS (STREET OR R.F.D. NO., CITY OR TOWN, STATE, ZIP): C.Z.Boyer & Son, Inc; Box 643; Desloge, Mo. 63601
25b. FUNERAL DIRECTOR—SIGNATURE: Carl B Shaw
25c. REG. NO.: 781
26a. REGISTRAR—SIGNATURE: M L Day
26b. DATE RECEIVED BY LOCAL REGISTRAR: October 24, 1973

NOV 16 1973

NOV 2 1973

NOV 1 1973

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 David G Shaw

Licensed Embalmer No. 5430

P. O. Address P. O. Box 643
Desloge, Missouri
63601

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.