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DECEDENT

INFORMANT

DISPOSITION

CERTIFIER

DECEDENT - NAME FIRST WALTER		MIDDLE ANTHONY		LAST KOZLOWSKI		SEX M.	DATE OF DEATH (Mo., Day, Yr.) July 31, 1998	
PLACE OF DEATH (City/Town) Holyoke		COUNTY OF DEATH Hampden		HOSPITAL OR OTHER INSTITUTION - Name (If not in either, give street and number) Holyoke Hospital				
PLACE OF DEATH (Check only one): HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		SOCIAL SECURITY NUMBER 094-14-9732		IF US WAR VETERAN SPECIFY WAR WWII		Korean		
WAS DECEDENT OF HISPANIC ORIGIN? (If yes, Specify Puerto Rican, Dominican, Cuban, etc.) <input checked="" type="checkbox"/> NO <input type="checkbox"/> YES		RACE (e.g. White, Black, American Indian, etc.) (Specify) White		DECEDENT'S EDUCATION (Highest Grade Completed) Elem/Sec (0-12) College (1-4, 5+) 12				
AGE - Last Birthday (Yrs.) 76	UNDER 1 YEAR MOS DAYS	UNDER 1 DAY HOURS MINS	DATE OF BIRTH (Mo., Day, Yr.) Nov. 26, 1921		BIRTHPLACE (City and State or Foreign Country) Schenectady, New York			
MARRIED, NEVER MARRIED WIDOWED OR DIVORCED Married	LAST SPOUSE (If wife, give maiden name) Margaret P. Comanzo		USUAL OCCUPATION (If retired) Vehicle Mechanic		KIND OF BUSINESS OR INDUSTRY U.S. Air Force			
RESIDENCE - NO. & ST., CITY/TOWN, COUNTY, STATE/COUNTRY 15a 37 Simone Road, Chicopee, Hampden, Mass., U.S.A.						ZIP CODE 15b 01013		
FATHER - FULL NAME 16 Albert Kozlowski		STATE OF BIRTH (If not in U.S. name country) 17 Poland		MOTHER - NAME (GIVEN) (MAIDEN) 18 Unknown		STATE OF BIRTH (If not in U.S. name country) 19 Poland		
INFORMANT'S NAME 20 Gregory Kozlowski		MAILING ADDRESS - NO. & ST., CITY/TOWN, STATE, ZIP CODE 21 37 Simone Road, Chicopee, Mass. 01013				RELATIONSHIP 22 Son		
METHOD OF DISPOSITION <input checked="" type="checkbox"/> BURIAL <input type="checkbox"/> CREMATION <input type="checkbox"/> ENTOMBMENT <input type="checkbox"/> REMOVAL FROM STATE <input type="checkbox"/> DONATION <input type="checkbox"/> OTH. SPEC.		FUNERAL SERVICE LICENSEE 24 Arthur J. Brunelle, III		LICENSE # 25 4813				
PLACE OF DISPOSITION (Name of Cemetery, Crematory or other) 26a St. Stanislaus Cemetery		LOCATION (City/Town, State) 26b Chicopee, Mass.						
DATE OF DISPOSITION (Mo., Day, Yr.) August 4, 1998		NAME AND ADDRESS OF FACILITY Chicopee, Mass., 01013 Arthur J. Brunelle Funeral Home, 811 Chicopee Street,						
PART I - Enter the diseases, injuries, or complications that caused the death. Do not use only the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line (a through d). PRINT OR TYPE LEGIBLY.		IMMEDIATE CAUSE (Final disease or condition resulting in death)		DUE TO (OR AS A CONSEQUENCE OF)		Approximate Interval Between Onset and Death		
		a CARDIAC ARREST				Immediate		
		b CARDIAC ARRYTHMIAS				Immediate		
		c CONGESTIVE HEART FAILURE				YEARS		
		d CHRONIC OBSTRUCTIVE LUNG DISEASE				twenty yrs		
PART II - Other significant conditions contributing to death but not resulting in underlying cause given in Part I		WAS AUTOPSY PERFORMED? (Yes or No) 31 NO		WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or No) 32				
WAS CASE REFERRED TO M.E.? (Yes or No) 33 NO		MANNER OF DEATH <input checked="" type="checkbox"/> NATURAL <input type="checkbox"/> HOMICIDE <input type="checkbox"/> ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> COULD NOT BE DETERMINED <input type="checkbox"/> PENDING INVESTIGATION		DATE OF INJURY (Mo., Day, Yr.) 35a		TIME OF INJURY 35b M		
DESCRIBE HOW INJURY OCCURRED 35d		PLACE OF INJURY - At home, farm, street, factory, office bldg., etc. Specify: 35e		LOCATION (No. & St., City/Town, State) 35f				
To be Completed by CERTIFYING PHYSICIAN ONLY 36a To the best of my knowledge, death occurred at the time, date, and place and due to the cause(s) stated (Signature and Title) 36b <i>Jimmy Glat</i>		DATE SIGNED (Mo., Day, Yr.) 36c <i>July 31 1998</i>		HOUR OF DEATH 36d <i>0505 AM</i>		To be Completed by MEDICAL EXAMINER 37a On the basis of examination and/or investigation in my opinion death occurred at the time, date, and place and due to the cause(s) stated (Signature and Title) 37b		
NAME AND ADDRESS OF CERTIFYING PHYSICIAN OR MEDICAL EXAMINER (Type or Print) 38 <i>RIMAT G. KHATAK MD 10 HOSPITAL DRIVE</i>		WAS THERE AN RN PRONOUNCEMENT? (Yes or No) 40a <i>NO</i>		IF YES, DATE PRONOUNCED 40b		IF YES, TIME PRONOUNCED 40c <i>M</i>		
DATE BURIAL PERMITTED 41 <i>AUG 08 1998</i>		SIGNATURE, RD. OF HEALTH AGENT <i>[Signature]</i>		RECEIVED IN THE CITY/TOWN OF: 42 <i>HOLYOKE</i>		CLERK'S SIGNATURE <i>[Signature]</i>		
						DATE OF RECORD 43 <i>AUG 3 1998</i>		

BLACK INK ONLY

R-301-89

I, the undersigned, hereby certify that I am the Clerk of the City of Holyoke; that, as such, I have the custody of the records of death required by law to be kept in my office; I do hereby certify that the above is a true copy from said records.

[Signature]
City Clerk

Mr. Strong,

On July 31, 1998 SSgt Walter A. Kozlowski passed away.

Walter Kozlowski served with the 306th on the crew of 1Lt. Martin Andrews. Aboard the "Special Delivery" B17.

Walter Kozlowski retired from the U.S. Air Force after 22 years of service and leaves one son.

If possible could you mail me a copy of the Echoes with the obituary of Walter A. Kozlowski.

Sincerely,

Gregory M. Kozlowski (Son)

Gregory M. Kozlowski
37 Simone Rd.
Chicopee, MA 01013-
3729