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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 17350

Registration District No. 399 Primary Registration District No. 1002 Registrar's No. 1877

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH
(a) County Jackson
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Mary's Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution
In this community 17 Yrs (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits write "RURAL")
(d) Street No. 4425 Troost Ave.
(If rural, give location)
(e) If foreign born, how long in U. S. A.? ..... years.

3. (a) PRINT FULL NAME Cleora M. Konrad 563

3. (b) If veteran, name war No

3. (c) Social Security No. 495-09-2252

4. Sex Fe

5. Color or race Wh

6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive ..... years

7. Birth date of deceased May 5, 1900 (Month) (Day) (Year)

8. AGE: Years 39 Months 11 Days 28 If less than one day ..... hr. ..... min.

9. Birthplace Batavia, Ill (City, town, or county) (State or foreign country)

10. Usual occupation Stenographer

11. Industry or business First Nat'l Bank

FATHER
12. Name Otto Konrad
13. Birthplace Weyawega, Wis (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Mary L. Feeney
15. Birthplace Batavia Ill. (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Mary L. Konrad
(b) Address 4425 Troost Ave.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-6-40 (Month) (Day) (Year)
(c) Place: burial or cremation Batavia, Ill

18. (a) Signature of funeral director Thos. E. Quirk
(b) Address 4316 Troost Ave.

19. (a) May 5, 1940 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 3 year 1940 hour 10 minute 55P M.

21. I hereby certify that I attended the deceased from 4-1-40, 19..., to 5-3-40, 19...; that I last saw h... alive on ..., 19...; and that death occurred on the date and hour stated above.

Duration

Immediate cause of death Subacute Bacterial Endocarditis

Due to Streptococcus Viridans

Due to Rheumatic Endocarditis, 566

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy Above

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury

23. Signature [illegible] (M. D. or other)
Address [illegible] Date signed

(Licensed Embalmer's Statement on Reverse Side)

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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed Thomas E. Quick

Licensed Embalmer No. 3775

P. O. Address 4316 Locust Av

Note:, The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.