No. 2
1-10-39
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X21492

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

DEC 15 1941

Registration District No. 30

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 37697

Primary Registration District No. 5041

Registrar's No. 49

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

1. PLACE OF DEATH:

(a) County Barry

(b) City or town Rural Cape Creek township
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: /
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether
In this community 45 yrs
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Barry 5

(c) City or town Rural 0
(If outside city or town limits write "RURAL")

(d) Street No. 4 mi south Pierce City
(If rural, give location)

(e) If foreign born, how long in U. S. A.? 0 years.

3. (a) PRINT FULL NAME Ophelia Korkoski

3. (b) If veteran, name war -

3. (c) Social Security No. none

4. Sex F /

5. Color or race W

6. (a) Single, widowed, married, divorced 9

6. (b) Name of husband or wife Joseph Korkoski

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

7. Birth date of deceased Sept (Month) 15 (Day) 1869 (Year)

8. AGE: Years 72 Months 1 Days 16 If less than one day hr. min.

9. Birthplace (City, town, or county) S Germany (State or foreign country)

10. Usual occupation House Wife

11. Industry or business Farmer

FATHER
12. Name John Washick
13. Birthplace (City, town, or county) S Germany (State or foreign country)

MOTHER
14. Maiden name Mlodick Kordala
15. Birthplace (City, town, or county) S Germany (State or foreign country)

16. (a) Informant Sophie Blowers
(b) Address Kansas City Kan

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov (Month) 3 (Day) 1941 (Year)
(c) Place: burial or cremation Pulaskifield cemetery

18. (a) Signature of funeral director Edwin Wilks
(b) Address Pierce City Mo

19. (a) 11-4-1941 (Date received local registrar) (b) W. M. West (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 1. year 1941 hour 8 minute 10 A. M.

21. I hereby certify that I attended the deceased from May 4, 1941, to Nov. 1, 1941; that I last saw her alive on Nov. 1, 1941; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Perforation of stomach and colon.	14 hrs.
Due to: Cancer of digestive organs and peritoneum	unknown
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

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 2

23. Signature Charles S Moore (M. D. or other) D.O.
Address Pierce City Mo Date signed Nov. 6/41

51

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 6,
District File Number 1241-1828
Date Filed DEC 11 1941

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, ~~under~~ Edwin Wilks, Registered Apprentice No. ..... working under my personal supervision.

Signed Edwin Wilks

Licensed Embalmer No. 4131

P. O. Address Pierce City Mo

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

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

S. No. 2B
I—8-21-41
I X29268

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 37697

Registration District No. 30 Primary Registration District No. 3041 Registrar's No.

SUPPLEMENTARY

1. PLACE OF DEATH:

(a) County: Barry

(b) City or town: Rural
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

(c) City or town
(If outside city or town limits, write "RURAL")

(d) Street No.
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME: Ophelia Korkock

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex: F.

5. Color or race: W.

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

6. (b) Name of husband or wife

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

7. Birth date of deceased: Sept. 13 (Month) 18 (Day) (Year)

8. AGE: Years 72 Months 1 Days If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name

13. Birthplace (City, town, or county) (State or foreign country)

14. Maiden name

15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant

(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 1941 year hour minute M.

21. I hereby certify that I attended the deceased from 19 to 19; that I last saw him alive on 19; and that death occurred on the date and hour stated above.

Duration

Immediate cause of death

Due to: Cancer of descending colon

Due to: Ascites

Due to: Began around spleen

Other conditions: Stenosis of colon.
(Include pregnancy within 3 months of death)

Major findings:
Of operations: none

Of autopsy: none. H6e

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) Nature of injury

23. Signature: Charles S. Moore (M. D. or other) M.D.

Address: Pierce City Mo. Date signed 1/8/42