No. 2
—1/47
5-17-39

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 15479

FILED JUN 7 1948

Registration District No. 42

Primary Registration District No. 1000

Registrar's No. 607

1. PLACE OF DEATH:

(a) County Buchanan

(b) City or town St, Joseph Mo.
(If outside city or town limits, write "RURAL" and name of township)

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

(d) Length of stay: In hospital or institution 30 Days (Specify whether
In this community Life
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan

(c) City or town St Joseph Mo.
(If outside city or town limits, write "RURAL")

(d) Street No. 220I So I4th Street
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME Lillian Markos

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Female

5. Color or race White

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 November (Month) 5th (Day) I877 (Year)

8. AGE:	Years	Months	Days	If less than one day
✓	70	6	26	hr. min.

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

10. Usual occupation House Work

11. Industry or business

FATHER
12. Name John Markos
13. Birthplace Unknown (City, town, or county) Bohemia (State or foreign country)

MOTHER
14. Maiden name Mary Adamack
15. Birthplace Unknown (City, town, or county) Bohemia (State or foreign country)

16. (a) Informant Helen Herynk
(b) Address 220I South I4 Th Str.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof June2 (Month) I948 (Day) (Year)
(c) Place: burial or cremation Mt Clivet Cemetery

18. (a) Signature of funeral director Herman Wm Sidenfaden
(b) Address St Joseph Mo.

19. (a) 6-1-48 (Date received local registrar) (b) E. C. Jenkins (Registrar's signature) SXL

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 3I
year I948 hour 2 minute 20 A M.

21. I hereby certify that I attended the deceased from May 1, 1948 to May 31, 1948;
that I last saw her alive on May 29, 1948;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Cold abscess, mid-dorsal spine. with Bone-cavities	— over 1 yr
Due to Compression spinal Cord + Cord Bladder	1 week
Due to Thoracic Dorsal Pedes artery	10 days
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

170

PHYSICIAN

Underline the cause of 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 Arthur Ovell (M. D. or other) MD.

Address 218 No. 7th Street St. Joseph, Mo. Date signed 6-1-48

Jefferson City Printing Co.

(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, Elmer Thomas

Licensed Embalmer No. 2640

P. O. Address St. Joseph Mo.

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 this body is not embalmed, fact should be so stated above.