

State File No. **40319**

✓ 0360
WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. 4183		Registrar's No. 851	
1. PLACE OF DEATH a. COUNTY <u>Franklin</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>MO</u> b. COUNTY <u>Franklin</u>			
b. CITY (If outside corporate limits, write RURAL and give township) <u>Pacific</u>		c. LENGTH OF STAY (In this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>RED Robertsville</u> 031		d. STREET ADDRESS (If rural, give location) <u>1111 E 12th</u>	
3. NAME OF DECEASED (Type or Print) <u>Louis</u>				a. (First) _____ b. (Middle) _____ c. (Last) <u>VONDERA</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Nov 19, 1950</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>Sept. 22, 1910</u>	
9. AGE (In years last birthday) <u>40</u>		10. F UNDER 1 YEAR Months _____		11. BIRTHPLACE (State or foreign country) <u>RED Robertsville MO</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>Frank VONDERA</u>				13b. MOTHER'S MAIDEN NAME <u>Minnie Understal</u>		14. NAME OF HUSBAND OR WIFE <u>Veronica Vondera</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>World War II</u>				16. SOCIAL SECURITY NO. <u>486-18-9824</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Veronica Vondera Robertsville, Mo</u>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Accidentally Struck By Frisco Train</u> ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>#2 at Pacific, MO Olivest. Crossing</u> DUE TO (c) <u>Fractured Skull</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Fractured Right Arm</u> <u>Crushed Chest</u>			
19a. DATE OF OPERATION _____				19b. MAJOR FINDINGS OF OPERATION _____			
20. AUTOPSY YES ☐ NO ☒							
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>Accident</u>				21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Pacific</u>			
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>Pacific Franklin MO</u>				21d. HOW DID INJURY OCCUR? _____			
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐							
22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.							
23a. SIGNATURE <u>W. P. Hoffman</u> (Degree or title) <u>Coroner</u>				23b. ADDRESS <u>St. Mary's Church</u>			
23c. DATE SIGNED <u>12/19/50</u>							
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				24b. DATE <u>Dec. 22, 1950</u>			
24c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's Church</u>				24d. LOCATION (City, town, or county) (State) <u>Robertsville Missouri</u>			
25. FUNERAL DIRECTOR'S SIGNATURE <u>See 22-50</u>				25. ADDRESS <u>See 22-50</u>			

MAR 14 1951

File No. _____
DISTRICT HEALTH OFFICE No. 4

JAN 8 1951

RECEIVED

VS
JUL 8 1951

JAN 13 1951

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 _____

working under my personal supervision.

Student Embalmer No.

Signed _____

W. W. Maubrink

Signed
Student Embalmer

Licensed Embalmer No. *4511*

P. O. Address *Washington, Ma.*

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.