

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH12030  
Dr. Turner

State File No. ....

ED APR 21 1952

BIRTH NO. _____		REG. DIST. NO. <u>128</u>		PRIMARY REG. DIST. NO. <u>2000</u>		Registrar's No. <u>364</u>	
1. PLACE OF DEATH a. COUNTY <u>Greene</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Webster</u>			
b. CITY (If outside corporate limits, write RURAL and give township) <u>Springfield</u>		c. LENGTH OF STAY (In this place) <u>12 Days</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Seymour</u>		<u>1129</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>St John's Hospital</u>				d. STREET ADDRESS (If rural, give location) <u>1</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Joseph</u> b. (Middle) _____ c. (Last) <u>Koskovick</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>April, 10, 1952</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		9. AGE (In years last birthday) <u>63</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (State or foreign country) <u>9</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13a. FATHER'S NAME <u>Wark</u>		13b. MOTHER'S MAIDEN NAME <u>Wark</u>		14. NAME OF HUSBAND OR WIFE <u>Mrs. Gertrude Koskovich</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Wark</u>		16. SOCIAL SECURITY NO. <u>Wark</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Gertrude Koskovich</u> ADDRESS _____			
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, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>SPONTANEOUS PNEUMOTHORAX</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 wks.</u> ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>PULMONARY TUBERCULOSIS ACTIVE, FAR ADVANCED.</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>002X</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>8-3</u> , 19 <u>45</u> , to <u>4/10/52</u> , 19 <u>52</u> , that I last saw the deceased alive on <u>4/10/52</u> , 19 <u>52</u> , and that death occurred at <u>6:30 P.</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>James R. Ames, M.D.</u> (Degree or title)				23b. ADDRESS <u>Springfield, Mo.</u>		23c. DATE SIGNED <u>4/11/52</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24b. DATE <u>4/12/52</u>	24c. NAME OF CEMETERY OR CREMATORY <u>ROGERSVILLE, MISSOURI</u>		24d. LOCATION (City, town, or county) (State) <u>Springfield, Mo.</u>		
DATE REC'D BY LOCAL REG. <u>4-14-52</u>		REGISTRAR'S SIGNATURE <u>James R. Ames, M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>H. H. Lohmeyer</u> ADDRESS <u>Springfield, Mo</u>			

(Licensed Embalmers' Statement on Reverse Side)

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

396  
0

**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: Wm. L. Swadley

Signed.....  
Student Embalmer

Licensed Embalmer No. 4815

P. O. Address Sevensfield

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.