

**THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH**

34256

State File No.

Registrar's No. **1137**

BIRTH NO. _____ REG. DIST. NO. **42** PRIMARY REG. DIST. NO. **1000**

1. PLACE OF DEATH			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).		
a. COUNTY Buchanan			a. STATE Missouri b. COUNTY Buchanan		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Joseph,		c. LENGTH OF STAY (In this place) 2 yrs	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Joseph, 0117		
d. FULL NAME OF HOSPITAL OR INSTITUTION 2835 So 20th St.			d. STREET ADDRESS 2835 So 20th (If rural, give location)		

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH		
a. (First) Frank	b. (Middle)	c. (Last) Konecne	(Month) 10	(Day) 31	(Year) 1952

5. SEX male 0	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED Married	8. DATE OF BIRTH 4/16/1870	9. AGE (In years last birthday) 82	# UNDER 1 YEAR Months 6	YEAR Days 15	# UNDER 2 HRS. Hours	MIN.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	10b. KIND OF BUSINESS OR INDUSTRY Farmer	11. BIRTHPLACE (State or foreign country) Corning, Iowa	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Frank Konecne	13b. MOTHER'S MAIDEN NAME Emaline Ellis	14. NAME OF HUSBAND OR WIFE Kate Konecne
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. none	17. INFORMANT'S SIGNATURE OR NAME Mrs. Elizabeth Meader	ADDRESS St. Joseph
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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		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral thrombosis		2 weeks
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) arterio sclerosis DUE TO (c) Chronic myocarditis		Not sure
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			Not sure

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION ✓	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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) 4221
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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?
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22. I hereby certify that I attended the deceased from Oct 24, 1952 to Oct 31, 1952; that I last saw the deceased alive on Oct 31, 1952; and that death occurred at 1:50 P.m., from the causes and on the date stated above.

23a. SIGNATURE (Degrees or title) Collis P. Rounley, M.D.	23b. ADDRESS Hurricane, Mo.	23c. DATE SIGNED Nov 1-52
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 11/2/52	24c. NAME OF CEMETERY OR CREMATORY Evergreen Cemetery	24d. LOCATION (City, town, or county) (State) Effingham Kansas
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DATE REC'D BY LOCAL REG. Nov. 5, 1952	REGISTRAR'S SIGNATURE Carl C. Casper	25. FUNERAL DIRECTOR'S SIGNATURE John E. ...	ADDRESS St. Joseph, Mo.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

0117

S. No. 300
V. 10.48

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~~ _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed *John E. Ruppel* _____

Licensed Embalmer No. *3586* _____

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.