

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **43947**  
Registrar's No. **11008**

FILED DEC 24 1952

318 PRIMARY REG. DIST. NO. 1003

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>Ill.</b> b. COUNTY <b>West Frankfort Rural Route</b>	
b. CITY (If outside corporate limits, write RURAL and give township) <b>ST Louis</b>		c. LENGTH OF STAY (In this place) <b>1-Month</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Firmin Desloge Hospt.</b>		d. STREET ADDRESS (If rural, give location) <b>8720</b>	
3. NAME OF DECEASED (Type or Print) a. (First) <b>Peter</b> b. (Middle) c. (Last) <b>Yurkonis</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>Nov. 28-52</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>Feb. 2-1889</b>
9. AGE (In years last birthday) <b>63</b>		10. KIND OF BUSINESS OR INDUSTRY <b>Miner</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Miner</b>		11. BIRTHPLACE (City and State or Foreign Country) <b>Lithuania</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13a. FATHER'S NAME <b>Peter Yurkonis</b>	
13b. MOTHER'S MAIDEN NAME <b>Unknown</b>		14. NAME OF HUSBAND OR WIFE <b>Anna Yurkonis</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT'S SIGNATURE OR NAME <b>Delia Engelthaler</b>		ADDRESS <b>Chicago Ill.</b>	
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) <b>Bronchogenic Carcinoma</b>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)  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	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR <b>162X</b>	
22. I hereby certify that I attended the deceased from <b>Oct 30, 1952</b> , to <b>Nov 28, 1952</b> , that I last saw the deceased alive on <b>Nov 27, 1952</b> and that death occurred at <b>3A m.</b> , from the causes and on the date stated above.			
23a. SIGNATURE <b>Paul Wimsby M.D.</b>		23b. ADDRESS <b>508 N Grand</b>	23c. DATE SIGNED <b>11-29-52</b>
24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE <b>Nov. 29-52</b>	24c. NAME OF CEMETERY OR-CREMATORY <b>West Frankfort Ill.</b>	24d. LOCATION (City, town, or county) (State)
DATE REC'D BY LOCAL REG. <b>DEC 1 1952</b>	REGISTRAR'S SIGNATURE <b>J. Carl Smith M.D.</b>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Union West Frankfort Ill.</b>	

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

1454

**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 Ronald Yubenko

Licensed Embalmer No. 3917

P. O. Address St Louis

**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.