

FILED SEP 29 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 31116

BIRTH NO. 70601-55 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 7983

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY			
b. CITY OR TOWN St. Louis MO		c. LENGTH OF STAY (in this place)		c. CITY OR TOWN St. Louis 7	
d. FULL NAME OF HOSPITAL OR INSTITUTION Christian Hospital		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
3. NAME OF DECEASED (Type or Print) a. (First) Victoria b. (Middle) Gunn c. (Last) Konick		4. DATE OF DEATH (Month) (Day) (Year) Sept 10 1955			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH Sept 10, 1955	9. AGE (In years) (If under 1 year last birthday) Months Days Hours Min. = - - - - - 6 29	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) St. Louis MO	
13a. FATHER'S NAME Michael Konick		13b. MOTHER'S MAIDEN NAME Florence Neumann		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME x Michael J. Konick	
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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) CONGENITAL ATRIALECTASIS ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) PREMATURE UTERINE DUE TO (c) Uterine Bleeding (month) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" 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 _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 8:45 p.m., from the causes and on the date stated above.					
23a. SIGNATURE (Degree or title) <i>Heath Graham MD</i>		23b. ADDRESS 820 W. Shaw St. - St. Louis MO		23c. DATE SIGNED 12 Sept 55	
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24b. DATE SEPT-12-55		24c. NAME OF CEMETERY OR CREMATORY CALVARY CEM	
24d. LOCATION (City, town, or county) ST. LOUIS -		24e. (State) MO			
DATE REC'D BY LOCAL REG. SEP 12 1955		REGISTRAR'S SIGNATURE <i>J. Carl Smith MD</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>L. B. Tanner</i> ADDRESS 6107 Natural Bridge	

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

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.....
Signature of Student Embalmer

Not Embalmed
Signed..... J. B. Turner

Licensed Embalmer No. 29
P. O. Address St. Louis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.