

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH
 42

58-004528
 STATE FILE NUMBER
 Registrar's No. **220**

FILED MAR 10 1958

Registration District No. _____ Primary Registration District No. **1000** Registrar's No. **220**

300
-57

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Buchanan	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph		c. CITY OR TOWN St. Joseph, Mo	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 701 So 11th		d. STREET ADDRESS 2835 So 20th	
3. NAME OF DECEASED (Type or print) First Kate Middle _____ Last Konecne		4. DATE OF DEATH Month Feb Day 27 Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 9, 1875
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House keeper		10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (City and state or country) Iatan Missouri
13a. FATHER'S NAME J.P. Azlein		13b. MOTHER'S MAIDEN NAME Bettie Callaway	14. NAME OF HUSBAND OR WIFE Frank, (de)
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	17. INFORMANT Elizabeth Meador Address St. Joseph Mo
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage			INTERVAL BETWEEN ONSET AND DEATH 4 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) arterio sclerotic heart disease			not sure
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 331X			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour _____ Month, Day, Year _____ a.m. _____ p.m. _____			
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
21. I attended the deceased from Feb 23 58 to Feb 27 58 and last saw her/him alive on Feb 27-58 Death occurred at 8:10 P.M. m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Colles Rounby M.D.		22b. ADDRESS 230 Northgate Truss Bldg	22c. DATE SIGNED March 1-58
23a. BURIAL, CREMATION, REINTERMENT (Specify)	23b. DATE 2/28/58	23c. NAME OF CEMETERY OR CREMATORY Evergreen Cemetery	23d. LOCATION (City, town, or county) (State) Effingham Kansas
24. FUNERAL DIRECTOR John B. Keefe ADDRESS St. Joseph, Mo		25. DATE RECD. BY LOCAL REG. March 5, 1958	26. REGISTRAR'S SIGNATURE Mrs. Clark Goodell

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. All diseases in Part I must be causally related.

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

Signed *John D. Rapp*

Licensed Embalmer No. *3986*

P. O. Address *St. Joseph*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.