

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-027905
STATE FILE NUMBER

HELD JUL 25 1958 Registration District No. 339 Primary Registration District No. 3074 Registrar's No. 132

1. PLACE OF DEATH a. COUNTY <u>Scott</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Scott</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Sikeston</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Sikeston</u> <u>1003</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Mo. Delta Comm. Hosp.</u> Length of stay in 1b <u>90 Min.</u>		d. STREET ADDRESS (If outside, give location) <u>411 Prosperity St.</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Neal</u> Middle <u>Daniel</u> Last <u>Kornegger</u>			4. DATE OF DEATH Month <u>7</u> Day <u>12</u> Year <u>1958</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-17-1894</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Highway Dept.</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>State Hwy.</u>	11. BIRTHPLACE (City and state or country) <u>Carmi, Illinois</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>L. B. Kornegger</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Seibert</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT <u>Mrs. Laura Kornegger, Sikeston, Mo.</u> Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) <u>4201</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 HRS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>① Shock Cardiac</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <u>2</u>
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 WORK <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 <u>7-12-58</u> to <u>7-12-58</u> and last saw <u>him</u> alive on <u>9:50 AM</u> Death occurred at <u>9:50 A</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Andrew B. Dr. M.D.</u>		22b. ADDRESS <u>Sikeston, Mo.</u>	22c. DATE SIGNED <u>7-12-58</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>7-14-58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>GARDEN OF MEMORIES</u>	23d. LOCATION (City, town, or county) (State) <u>Sikeston MO</u>
24. FUNERAL DIRECTOR ADDRESS <u>Welsh Funeral Home - Sikeston Mo</u>		25. DATE RECD. BY LOCAL REG. <u>7-19-58</u>	26. REGISTRAR'S SIGNATURE <u>Miss Ellen Hunter</u>

(Licensed Embolmer's Statement on Reverse Side)

Health, Welfare Public Service 300 1-56
Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

DATE RECEIVED 7-21-58

AUG 14 1958

SCOTT CO. HEALTH DEPT.

75-8-177

FEB 9 1958

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 Raymond Ciewa
Licensed Embalmer No. 34

P. O. Address Sikeston

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.