

Health,
& Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-016319

STATE FILE NUMBER

FILED APR 27 1959

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 1101

S. 300
1-57

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| 1. PLACE OF DEATH a. COUNTY ST LOUIS | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO b. COUNTY ST LOUIS | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN AFFTON | | c. CITY OR TOWN AFFTON 4860 | |
| Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 8426 HAMPSTEAD | | d. STREET ADDRESS 8426 HAMPSTEAD | |
| Length of stay in lb YRS. | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last MARIE (KUH) KONCZAKOWSKI | | | 4. DATE OF DEATH Month Day Year APR. 21, 1959 |
| 5. SEX FEMALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH JAN 7, 1888 |
| 10a. USUAL OCCUPATION (Give kind of work done during any of working life, even if retired) AT HOME | | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (City and state or country) EUROPE 4 |
| 13a. FATHER'S NAME JOHN SURICH | | 13b. MOTHER'S MAIDEN NAME NOT KNOWN | 14. NAME OF HUSBAND OR WIFE EDWARD (DECEASED) |
| 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 Address THELMA SCHMIDT, 8426 HAMPSTEAD |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma of the Rectum | | | INTERVAL BETWEEN ONSET AND DEATH 2 yrs |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Anemia due to metastatic Carcinoma | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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 8-31-58 Present to 3-21-59 and last saw her alive on 3-21-59 | | Death occurred at 1:00 A m on the date stated above; and to the best of my knowledge, from the causes stated. | |
| 22a. SIGNATURE (Degree or title) Blair Byrne, MD | | 22b. ADDRESS 4660 Maryland | 22c. DATE SIGNED 4/28/59 |
| 23a. PRIMARY CREMATION, REMOVAL (S.S. No.) BORIAL | | 23b. DATE 4/28/59 | 23c. NAME OF CEMETERY OR CREMATORY N ST MARCUS CEM. |
| | | 23d. LOCATION (City, town, or county) (State) ST LOUIS MO. | |
| 24. FUNERAL DIRECTOR ADDRESS J L ZIEGENHEIN & SONS 7027 GRAVOIS | | 25. DATE RECD. BY LOCAL REG. 4-21-59 | 26. REGISTRAR'S SIGNATURE John C. Murphy M.D. |

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. 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 *C. P. Kedwell*

Licensed Embalmer No. *3877*
P. O. Address *7027 Graves*

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.