

**FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

FILED VS JUL 11 1960

**=60-025820**

STATE FILE NUMBER

Registration District No. 38 Primary Registration District No. 3006 Registrar's No. 383

1. PLACE OF DEATH a. COUNTY <u>Boone</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Shannon</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Columbia</u>		Length of stay in 1b <u>76 Days</u>	c. CITY OR TOWN <u>Birch Tree</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>University of Missouri Medical Center</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>Route 1</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <u>Obert Conrad Kragnes</u>			4. DATE OF DEATH Month Day Year <u>7 3 1960</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>10/1/02</u>	9. AGE (last birthday) <u>57</u>	IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARMER</u>	11. BIRTHPLACE (City and state or country) <u>Felton, Miss</u>		12. CITIZEN OF WHAT COUNTRY <u>United States</u>	
13a. FATHER'S NAME <u>Gilbert KRAGNES</u>		13b. MOTHER'S MAIDEN NAME <u>Elsie Skolid</u>		14. NAME OF HUSBAND OR WIFE <u>Myrtle Kragnes</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>469-05-3856</u>		17. INFORMANT Address <u>Medical Records Columbia Mo</u>		

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>DISSEMINATED CARCINOMA PROSTATE</u>		INTERVAL BETWEEN ONSET AND DEATH <u>UNKNOWN</u>
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)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
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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 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 <u>4/20/60</u> to <u>7/3/60</u> and last saw her/him alive on <u>7/3/60</u>	COUNTY	STATE
21. I attended the deceased from <u>4:30 p.</u> on the date stated above, and to the best of my knowledge, from the causes stated.				

22a. SIGNATURE (Degree or title) <u>Thomas W. Burns, M.D.</u>	22b. ADDRESS <u>J. of Missouri Medical Center,</u>	22c. DATE SIGNED <u>7/3/60</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	23b. DATE <u>7-5-1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MEMORIAL GARDENS MINNEAPOLIS MINNESOTA</u>	23d. LOCATION (City, town, or county) (State)
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24. FUNERAL DIRECTOR <u>PARKER FUNERAL SERVICE</u>	ADDRESS <u>Colum B-2 Missouri</u>	25. DATE RECD. BY LOCAL REG. <u>July 4 1960</u>	26. REGISTRAR'S SIGNATURE <u>Mrs R E Palmer</u>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

JUL 12 1960

JUL 15 1960

AUG 4 1960

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Donald L. Kabe

Licensed Embalmer No. 4922  
P. O. Address Columbia

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.