

IRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-036923

FILED VS OCT 10 1960

317

Primary Registration District No. 547

Registrar's No. 2777

STATE FILE NUMBER

INDEXED

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <b>St. Louis,</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>ST LOUIS</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Richmond Heights,</b>		Length of stay in 1b <b>WKS.</b>	c. CITY OR TOWN <b>Ladue,</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St Marys Hosp.</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>#3 Wakefield Dr.</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>ANTON (TONY)</b> Middle <b>A.</b> Last <b>KONVICKA</b>			4. DATE OF DEATH Month <b>Sept.</b> Day <b>18th,</b> Year <b>1960</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>3-4-1913</b>	9. AGE (last birthday) <b>47</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Sales Manager</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Holbart Sales Agcy.</b>	11. BIRTHPLACE (City and state or country) <b>Weimar, Texas.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
13a. FATHER'S NAME <b>Anton A. Konvicka</b>		13b. MOTHER'S MAIDEN NAME <b>Constance Unknown</b>		14. NAME OF HUSBAND OR WIFE <b>Murial D. Konvicka</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes W. War #2</b>		16. SOCIAL SECURITY NO. <b>_____</b>		17. INFORMANT <b>Murial D. Konvicka-#3 Wakefield Dr. Ladue</b> 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) <b>Septicemia</b>					INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Abscess &amp; necrosis of tongue &amp; muscle of larynx</b>					<b>2 month</b>
DUE TO (c) <b>Malignant Lymphoma, Reticular Cell Type</b>					<b>5 years</b>
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
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 a.m. p.m. Month, Day, Year					
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 <b>2-8-55</b> to <b>9-18-60</b> and last saw her/him alive on <b>9-17-60</b> Death occurred at <b>4:00 A.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <b>Frank J. Mangano</b> (Degree or title)		22b. ADDRESS <b>1617 S. Brentwood</b>		22c. DATE SIGNED <b>9-19-60</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>Sept. 21, 1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Calvary Mausoleum</b>	
23d. LOCATION (City, town, or county) <b>St. Louis,</b>		Mo.			
24. FUNERAL DIRECTOR <b>Kriegshausner-9450 Olive St. Rd.</b>		25. DATE RECD. BY LOCAL REG. <b>9-19-60</b>		26. REGISTRAR'S SIGNATURE <b>John C. Murphy M.D.</b>	

**STATEMENT BY LICENSED EMBALMER**

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

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

Signed R.W. Storvick

Licensed Embalmer No. 400

P. O. Address H. Lau

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