

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-011122

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1100

FILED MAR 19 1962

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|---------------|-----------------|--|------------|----------|
| VS 300 | DATE AMENDED | AMENDMENTS ON THIS RECORD ARE AS FOLLOWS | INSTEAD OF | DOCUMENT |
| Rev. 4/59 | | | | |
| 1 | | | | |
| 2 <u>3078</u> | | | | |
| 3 | | | | |
| 4 <u>1</u> | | | | |
| 5 <u>2</u> | | | | |
| 6 | | | | |
| 7 <u>2</u> | | | | |
| 8 <u>2</u> | | | | |
| 9 <u>332X</u> | | | | |
| 10 | | | | |
| 11 | | | | |
| 12 <u>860</u> | | | | |
| 13 | | | | |
| | BY AFFIDAVIT OF | | | |
| | ITEM NO. | SHOULD READ | | |

| | | | |
|--|---|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>JACKSON</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> COUNTY <u>JACKSON</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>KANSAS CITY</u> | | Length of stay in 1b <u>64 YRS.</u> | c. CITY OR TOWN <u>KANSAS CITY</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>BRATON NURSING HOME</u> | | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | d. STREET ADDRESS (If outside, give location) <u>343 N. DENVER</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>LILLIAN ALICE KONIZESKI</u> | | | 4. DATE OF DEATH Month Day Year <u>2 - 22 - 1962</u> |
| 5. SEX <u>FEMALE</u> | 6. COLOR OR RACE <u>WHITE</u> | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>10-1-1878</u> |
| 9. AGE (last birthday) <u>83</u> | | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HR Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during 1 year, even if retired) <u>HOUSEWIFE</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u> | 11. BIRTHPLACE (City and state or country) <u>ENGLAND</u> |
| 12. CITIZEN OF WHAT COUNTRY <u>U;S.A.</u> | | 13. FATHER'S NAME <u>SAMUEL WARNER</u> | |
| 14. MOTHER'S MAIDEN NAME <u>ROSE ANN HOLMES</u> | | 15. NAME OF HUSBAND OR WIFE <u>SAM KONIZESKI</u> | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u> | | 17. SOCIAL SECURITY NO. <u>*****</u> | 17. INFORMANT <u>MRS. WILL CRACRAFT</u> Address <u>405 S. BRIGHT K.C. 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>Cerebral Thrombosis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Senility</u> 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 | | | INTERVAL BETWEEN ONSET AND DEATH <u>27 hrs</u> <u>5 yrs</u> |
| 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 a.m. <u>9:15</u> Month, Day, Year <u>2-22-62</u> | 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>1959</u> to <u>2-22-62</u> and last saw her alive on <u>2-22-62</u> Death occurred at <u>9:15 a.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated. | | | |
| 22. SIGNATURE (Dentist or title) <u>Paul Fink MD</u> | | 22b. ADDRESS <u>814 Prof Bldg</u> | |
| 22c. DATE SIGNED <u>2-23-62</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | 23b. DATE <u>2-24-62</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>MEMORIAL PARK CEM.</u> | |
| 23d. LOCATION (City, town, or county) <u>KANSAS CITY, MISSOURI</u> | | | |
| 24. FUNERAL DIRECTOR <u>C; H. BLACKMAN & SON I" C. K.C. MO.</u> | | 25. DATE RECD. BY LOCAL REG. <u>2-23-62</u> | |
| 26. REGISTRAR'S SIGNATURE <u>Ruth Long</u> | | | |

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 W.C. Rivine

Licensed Embalmer No. 4879

P. O. Address K.P. Mission

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.