

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-046482

STATE FILE NUMBER

Registration District No. 119 Primary Registration District No. 5943 Registrar's No. 1

DO NOT WRITE ON THIS STUB

AMENDED

FILED JAN 10 1963	
1. PLACE OF DEATH a. COUNTY <u>GASCONADE</u>	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO.</u> b. COUNTY <u>GASCONADE</u>
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>YORK TWP</u> Length of stay in 1b <u>2 YEARS</u>	c. CITY OR TOWN <u>Owensville</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>FRENE VALLEY INC.</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>NONE</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED First Middle Last <u>THERESA ELIZABETH KRONE</u>	
4. DATE OF DEATH Month Day Year <u>DEC. 31, 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>7-12-74</u>
9. AGE (last birthday) <u>88</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>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>House Keeping</u>
11. BIRTHPLACE (City, and state or country) <u>Owensville MO.</u>	
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>ALBERT KOSARK</u>	13b. MOTHER'S MAIDEN NAME <u>ELLEN REED</u>
14. NAME OF HUSBAND OR WIFE <u>JAMES KRONE</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) (If yes, give war and type of service) <u>NO</u>	
16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT Address <u>WILLIAM FISHER Owensville 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>Pneumonia</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 INTERVAL BETWEEN ONSET AND DEATH <u>3 days</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. p.m. Month, Day, Year	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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>July 30, 1960</u> to <u>Dec 31, 1962</u> and last saw her/him alive on <u>Dec. 28, 1962</u> Death occurred at <u>4:00 PM</u> m on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE (Degree or title) <u>Paul T. Shaw, M.D.</u>	22b. ADDRESS <u>Hermann, Mo.</u>
22c. DATE SIGNED <u>1-2-63</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>1-3-63</u>
23c. NAME OF CEMETERY OR CREMATORY <u>CATHOLIC CEM.</u>	
23d. LOCATION (City, town, or county) (State) <u>Owensville Mo.</u>	
24. FUNERAL DIRECTOR ADDRESS <u>Gottenstroeter Service, Owensville, Mo</u>	25. DATE RECD. BY LOCAL REG. <u>1-2-63</u>
26. REGISTRAR'S SIGNATURE <u>Delmas Uffelman</u>	

DATE AMENDED
 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 SHOULD READ
 BY AFFIDAVIT OF

VS 300 Rev. 4/59

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USE BLACK INK OR TYPEWRITER RIBBON

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 Jerry A. Thompson
Licensed Embalmer No. 5165

P. O. Address Owensville, Mo.

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.