

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

12423-62-048500
STATE FILE NUMBER

318 1003
Registration District No. Primary Registration District No. Registrar's No.

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 12423-62-048500

FILED JAN 2 1962

VS 300 Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. SHOULD READ

INSTEAD OF DOCUMENT MEDICAL CERTIFICATION

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY <u>ST. LOUIS</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>ST. LOUIS</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS</u>		c. CITY OR TOWN <u>ST. LOUIS</u>	
Length of stay in 1b <u>42 YRS</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>DE-PAUL-HOSPITAL</u>		d. STREET ADDRESS (If outside, give location) <u>5400-WEST-FLORISSANT</u>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>MICHAEL</u> Middle <u>KONRAD</u> Last <u>KONRAD</u>			4. DATE OF DEATH Month <u>DEC.</u> Day <u>24</u> Year <u>1962</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>12-13-1896</u>	9. AGE (last birthday) <u>66 YRS.</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED-PAINTER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>KRUEPPELMANN PAINTING-CO</u>		11. BIRTHPLACE (City and state or country) <u>ZEMUN-YUGOSLAVIA</u>	
12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>		13a. FATHER'S NAME <u>JOSEPH-KONRAD</u>		13b. MOTHER'S MAIDEN NAME <u>ROSINA-BUCHMULLER</u>	
14. NAME OF HUSBAND OR WIFE <u>ROSE-KONRAD (DECD.)</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO NONE</u>			
17. INFORMANT <u>ADAM-KONRAD = 5540-PARTRIDGE</u>				Address <u>5540-PARTRIDGE</u>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Chr. Uremia</u>		<u>1 Mo.</u>
DUE TO (b) <u>Chr. Pyelonephritis</u>		<u>1 Year</u>
DUE TO (c) <u>Renal Stenosis</u>		<u>5 Yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>602x</u>		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 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.) <u>602x</u>
20c. TIME OF INJURY Hour <u> </u> Month, Day, Year <u> </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.) <u>Aug 10 - 62</u>	20f. CITY, TOWN, OR LOCATION <u>ST. LOUIS</u>	COUNTY <u> </u> STATE <u> </u>
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21. I attended the deceased from Aug 10 - 62 to DEC 24 62 and last saw him alive on DEC - 24 62
Death occurred at 7:50 P.m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Francis M. Webb MD</u>	(Degree or title) <u>MD</u>	22b. ADDRESS <u>1114W Hounsfield</u>	22c. DATE SIGNED <u>12/26/62</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>DEC. 28 - 1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>CALVARY-CEMETERY</u>	23d. LOCATION (City, town, or county) (State) <u>ST. LOUIS MO.</u>
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24. FUNERAL DIRECTOR <u>Brockland Und. Co.</u>	ADDRESS <u>1827-HOGAN-ST.</u>	25. DATE RECD. BY LOCAL REG. <u>DEC 26 1962</u>	26. REGISTRAR'S SIGNATURE <u>Carl Smith. M.D.</u>
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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 Harry E. Mansur

Licensed Embalmer No. 4495

P. O. Address St. Louis

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.