

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

851

State File No. ....

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 118 PRIMARY REG. DIST. NO. 4190 Registrar's No. 1

1. PLACE OF DEATH a. COUNTY <u>Gasconade</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Gasconade</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Bland</u>		c. LENGTH OF STAY (in this place) <u>39 yrs</u>	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Bland</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION ✓			d. STREET ADDRESS (If rural, give location) ✓			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Frank</u>		b. (Middle) <u>D</u>		c. (Last) <u>Homfeldt</u>		
4. DATE OF DEATH (Month) (Day) (Year) <u>Jan. 2 1949</u>		5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>3-30-1879</u>		9. AGE (In years last birthday) <u>68</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>merchant</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Missouri</u>		
12. CITIZEN OF WHAT COUNTRY? ✓		13a. FATHER'S NAME <u>Detrick Homfeldt</u>		13b. MOTHER'S MAIDEN NAME <u>Ollie Boetcher</u>		
14. NAME OF HUSBAND OR WIFE <u>Sophia</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. ✓		
17. INFORMANT'S SIGNATURE OR NAME <u>Mrs Sophia Homfeldt</u>		ADDRESS				
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Rt. Hemiplegia - Cerebral</u> ANTECEDENT CAUSES <u>Hemorrhage/Due To Hypertension</u> DUE TO (b) <u>Arteriosclerosis, Advanced</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS <u>None</u> Conditions contributing to the death but not related to the disease or condition causing death.			INTERVAL BETWEEN ONSET AND DEATH <u>3 dys</u> <u>8 yrs</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>None</u>			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>Bland Gasconade Mo.</u>		
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>0</u>		
22. I hereby certify that I attended the deceased from <u>12-31, 1948</u> to <u>1-2, 1949</u> , that I last saw the deceased alive on <u>1-1, 1949</u> , and that death occurred at <u>4 A. m.</u> , from the causes and on the date stated above.						
23a. SIGNATURE <u>Paul Brenner, MD</u>			23b. ADDRESS <u>Doverville, Mo.</u>		23c. DATE SIGNED <u>1-4-49</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Jan 4-1948</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Union Cemetery - Bland</u>		24d. LOCATION (City, town, or county) (State) <u>Bland Mo.</u>	
DATE REC'D BY LOCAL REG <u>Jan. 5, 1948</u>		REGISTRAR'S SIGNATURE <u>Rosothy Mackinaw</u>		FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Sassaman's Funeral Service</u>		

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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RECEIVED  
District Health Officer No. 9,  
District File Number JAN 10 1949  
Date Filed

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.

Signed *Chester Sasemann*

Signed.....  
Student Embalmer

Licensed Embalmer No. *4178*

P. O. Address *Bland - 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 this body is not embalmed, fact should be so stated above.