

FILED MAY 25, 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **15310**

BIRTH NO. _____		REG. DIST. NO. <u>77</u>		PRIMARY REG. DIST. NO. <u>3016</u>		Registrar's No. <u>127</u>	
1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
a. COUNTY <u>Cole</u>		b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Jefferson City</u> ( <u>1</u> )		c. LENGTH OF STAY (In this place) <u>18 days</u>		a. STATE <u>Missouri</u> b. COUNTY <u>Osage</u> <u>76</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION: <u>St Mary's Hospital</u>				c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Frankenstien</u> <u>8</u>			
d. STREET ADDRESS (If rural, give location) <u>1</u>							
3. NAME OF DECEASED			4. DATE OF DEATH				
a. (First) <u>Joseph Michael</u>		b. (Middle) _____		c. (Last) <u>Dudenhoeffer</u>		a. (Month) <u>May</u> (Day) <u>15</u> (Year) <u>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>4-13-1863</u>	
9. AGE (In years last birthday) <u>85</u>		10. UNDER 1 YEAR Months <u>10</u> Days <u>28</u>		11. UNDER 24 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>Cincinnati Ohio</u> <u>1</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13a. FATHER'S NAME <u>Mike Dudenhoeffer</u>		13b. MOTHER'S MAIDEN NAME <u>unknown</u>		14. NAME OF HUSBAND OR WIFE <u>Anna Marie Koengsfield</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>Paul Dudenhoeffer Bonnotsmill Mo</u> ADDRESS _____			
18. CAUSE OF DEATH		MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
Enter only one cause per line for (a), (b), and (c)		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Obstructive jaundice</u>				<u>4 weeks</u>	
*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES					
		Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.				<u>4 mo</u>	
		DUE TO (b) <u>Ca of Head of Pancreas (PANCREAS)</u>					
		DUE TO (c) _____					
		II. OTHER SIGNIFICANT CONDITIONS				<u>157X</u>	
		Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				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) _____			
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? _____			
22. I hereby certify that I attended the deceased from <u>Sept</u> , 19 <u>46</u> , to <u>May 15</u> , 19 <u>49</u> , that I last saw the deceased alive on <u>May 15</u> , 19 <u>49</u> , and that death occurred at <u>6:45 pm.</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>L. B. Klebba M.D.</u> (Degree or title)				23b. ADDRESS <u>Jefferson City Mo</u>		23c. DATE SIGNED <u>5-17-49</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>5-18-49</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Frankenstein</u>		24d. LOCATION (City, town, or county) (State) <u>Frankenstein Mo</u>	
DATE REC'D BY LOCAL REG. <u>May 17-49</u>		REGISTRAR'S SIGNATURE <u>R.P. Davis M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Clayde Mottor Linn. Mo</u>		ADDRESS _____	

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED  
District Health Officer No. 9  
District File Number  
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.

Student .....  
Student Embalmer

Signed Vernon M. Morton

Licensed Embalmer No. H/25

P. O. Address Lima, 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.