

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED JAN 9 1950

BIRTH NO. _____ REG. DIST. NO. 119 PRIMARY REG. DIST. NO. 4193 Registrar's No. 36

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>HERMANN</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Hermann, Mo</u>	
c. LENGTH OF STAY (in this place) <u>6 hrs.</u>		d. STREET ADDRESS (If rural, give location) <u>4th St.</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>WORKMAN HOSPITAL</u>			

3. NAME OF DECEASED (Type or Print) a. (First) <u>GUSSIE M.</u> b. (Middle) <u>JOERDEN</u> c. (Last) <u>JOERDEN</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Dec. 3-1949</u>		
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Feb. 25-1870</u>	9. AGE (In years last birthday) <u>79</u>	10. UNDER 1 YEAR <u>9</u>	11. UNDER 1 HRS. <u>8</u>	
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 _____		11. BIRTHPLACE (State or foreign country) <u>Hermann Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	

13a. FATHER'S NAME <u>Simon Maushand</u>	13b. MOTHER'S MAIDEN NAME <u>Marie Rasche</u>	14. NAME OF HUSBAND OR WIFE <u>Joseph Joerden</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Laura C. Walker</u>	ADDRESS <u>Hermann</u>
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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>Intestoch anterior fract. rt. femur</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 days</u>
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Blindness - cause unknown</u>		# <u>20</u>

19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION _____	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>Accident</u>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>home</u>	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>Hermann Gasconade Mo.</u>
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>12-2-49 4a.m.</u>	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>Fell in bathroom</u>
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22. I hereby certify that I attended the deceased from 2-1-, 1949, to 12-3, 1949, that I last saw the deceased alive on 12-3, 1949, and that death occurred at 4:35P m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Cavel T. Shaw MD</u>	23b. ADDRESS <u>Hermann Mo</u>	23c. DATE SIGNED <u>12-6-49</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>12/6/49</u>	24c. NAME OF CEMETERY OR CREMATORY <u>City Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>Hermann Mo</u>
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DATE REC'D BY LOCAL REG. <u>12/6/49</u>	REGISTRAR'S SIGNATURE <u>[Signature]</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>	ADDRESS <u>Hermann Mo.</u>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED
JAN 4 1950
District Health Officer No. 9,
District File Number.

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 _____

Signed.....

Student Embalmer

Licensed Embalmer No. 2044

P. O. Address Herrmann

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.