

**THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH**

FILED MAR 6 1950

State File No. 4502

S. No. 300
v. 10.48

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

BIRTH NO. _____		REG. DIST. NO. <u>128</u>		PRIMARY REG. DIST. NO. <u>2000</u>		Registrar's No. <u>169</u>		
1. PLACE OF DEATH a. COUNTY <u>Greene</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Texas</u>				
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Springfield</u>		c. LENGTH OF STAY (in this place) <u>3 days</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Cabool</u>		<u>7070</u>		
d. FULL NAME OF HOSPITAL OR INSTITUTION: <u>St Johns Hospital</u>				d. STREET ADDRESS (If rural, give location) <u>No street address</u>				
3. NAME OF DECEASED (Type or Print) a. (First) <u>Kathrine</u>			b. (Middle) <u>Clement</u>		c. (Last) <u>Fritsche</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>February 23 1950</u>	
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>Sept 30, 1878</u>	9. AGE (In years last birthday) <u>71</u>	IF UNDER 1 YEAR Months Days	IF UNDER 4 HRS. 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>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Luxemburg, Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13a. FATHER'S NAME <u>Mathias Clement</u>			13b. MOTHER'S MAIDEN NAME <u>Mary Hengel</u>		14. NAME OF HUSBAND OR WIFE _____			
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. <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Rose Hengel, Cabool, Missouri</u>				
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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>① Basal Skull Fracture</u> <u>② Compound fracture right leg</u> <u>③ Fracture right forearm</u> <u>④ Fracture left forearm</u> ANTECEDENT CAUSES <u>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</u> DUE TO (b) _____ DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>E 8 1/4</u> <u>30</u>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.								
19a. DATE OF OPERATION <u>None</u>		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT (Specify) SUICIDE HOMICIDE <u>accident</u>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Street</u>		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>Cabool</u> <u>Missouri</u>				
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>Feb. 20 1950 P.m.</u>		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Struck by auto 107</u>				
22. I hereby certify that I attended the deceased from <u>Feb. 20, 1950</u> , to <u>Feb. 23, 1950</u> , that I last saw the deceased alive on <u>Feb. 22, 1950</u> , and that death occurred at <u>5:00 A.m.</u> , from the causes and on the date stated above.								
23a. SIGNATURE <u>James D. Horton M.D.</u>				23b. ADDRESS <u>Springfield, Mo.</u>		23c. DATE SIGNED <u>2/25/50</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial #1</u>		24b. DATE <u>Feb. 25, 1950</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Cabool Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Cabool, Missouri</u>		
DATE REC'D BY LOCAL REG. <u>2-28-50</u>		REGISTRAR'S SIGNATURE <u>W.E. Handley M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Alma Schmeier</u>		ADDRESS <u>Springfield, Mo</u>		

MAR 6 1950

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 Bernard F. Wright

Licensed Embalmer No. 4293

P. O. Address Springfield, Vt.

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.