

FILED JUN 3 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **16227**

Registrar's No. **126**

BIRTH NO. _____ REG. DIST. NO. **77** PRIMARY REG. DIST. NO. **3016**

1. PLACE OF DEATH a. COUNTY St. Marys Hospital J.C.Mo		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo b. COUNTY: Co	
b. CITY (If outside corporate limits, write RURAL and give township) Jefferson City		c. CITY (If outside corporate limits, write RURAL and give township) Centertown Mo	
c. LENGTH OF STAY (In this place) 3yrs		d. STREET ADDRESS (If rural, give location) 0260	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Marys Hospital			

3. NAME OF DECEASED (Type or Print) a. (First) Donna b. (Middle) Maxine c. (Last) Koetting			4. DATE OF DEATH (Month) (Day) (Year) May-25-50		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never	8. DATE OF BIRTH 4-6-1947	9. AGE (In years last birthday) 3 IF UNDER 1 YEAR Months 1 Days 19 IF UNDER 24 HRS. Hours 1 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Jefferson City Mo.	
				12. CITIZEN OF WHAT COUNTRY USA	

13a. FATHER'S NAME Henry Koetting	13b. MOTHER'S MAIDEN NAME Esther Shroer	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. _____	17. INFORMANT'S SIGNATURE OR NAME Henry (Father) Koetting	ADDRESS Centertown Mo
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH Shock from		INTERVAL BETWEEN ONSET AND DEATH 89170
ANTECEDENT CAUSES Accidental 2° x 3°		DUE TO (b) Business of 60%		
		DUE TO (c) of body area 17		
II. OTHER SIGNIFICANT CONDITIONS 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"/>
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21a. ACCIDENT SUICIDE (Specify) <input checked="" type="checkbox"/>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) home	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) Centertown Mo.
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) 5-17-50 a	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? Fell in tub of water

22. I hereby certify that I attended the deceased from **5/17, 1950**, to **5/25, 1950** that I last saw the deceased alive **5-25, 1950**, and that death occurred at **1:50 a. m.**, from the causes and on the date stated above.

23a. SIGNATURE A. Ossman (Degree or title)	23b. ADDRESS Jefferson City, Mo	23c. DATE SIGNED 5/26/50
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 5-27-50	24c. NAME OF CEMETERY OR CREMATORY Riverview	24d. LOCATION (City, town, or county) (State) Jefferson City Mo.
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DATE REC'D BY LOCAL REG. May 26-1950	REGISTRAR'S SIGNATURE R.P. Dorrie MS-NR 68	25. FUNERAL DIRECTOR'S SIGNATURE Victor P. Burcher	ADDRESS 729 Capital
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

764

RECEIVED MAY 30 1968
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 Bill C. Brunner

Signed.....
Student Embalmer

Licensed Embalmer No. 4764

P. O. Address.....

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.