

FILED SEP 13 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

26532

State File No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 112 PRIMARY REG. DIST. NO. 5429 Registrar's No. 31

1. PLACE OF DEATH a. COUNTY <u>FRANKLIN</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before institution) a. STATE <u>MISSOURI</u> b. COUNTY <u>FRANKLIN</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>LYON TOWNSHIP</u>		c. LENGTH OF STAY (In this place) <u>ENTIRE LIFE</u>	
c. CITY (If outside corporate limits, write RURAL and give township) <u>LYON TOWNSHIP</u>		d. STREET ADDRESS (If rural, give location) <u>New Haven RFD</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION		e. FULL NAME OF HOSPITAL OR INSTITUTION	
3. NAME OF DECEASED (Type or Print) a. (First) <u>FARLEY</u>		b. (Middle) <u>C.F.</u>	
c. (Last) <u>KORFF</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>8-14-1950</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>9-1-1925</u>
9. AGE (In years last birthday) <u>24</u>		10. IF UNDER 1 YEAR Months <u>11</u> Days <u>13</u> Hours <u>13</u> Min.	
10a. USUAL OCCUPATION (Give kind of work during most of working life, even if retired) <u>FARMING</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARMING</u>	
11. BIRTHPLACE (State or foreign country) <u>NEW HAVEN, MO.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13a. FATHER'S NAME <u>AUGUST KORFF</u>		13b. MOTHER'S MAIDEN NAME <u>AGUSTE SCHEER</u>	
14. NAME OF HUSBAND OR WIFE <u>OPAL KORFF</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>YES WORLD WAR 2</u>	
16. SOCIAL SECURITY NO. <input checked="" type="checkbox"/>		17. INFORMANT'S SIGNATURE OR NAME <u>Mr. Aug. Korff New Haven Mo</u>	
18. ADDRESS <u>New Haven Mo</u>		19. ADDRESS <u>New Haven Mo</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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Struck By Lightning</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>in milk house</u> DUE TO (c) 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"/>		21. INTERVAL BETWEEN ONSET AND DEATH <u>22</u>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>LIGHTNING</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>New Haven Franklin Mo</u>		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) <u>6 P</u>	
21e. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Struck By Lightning</u>	
22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.			
23a. SIGNATURE <u>Pho. P. Stoffer</u> (Degree or title)		23b. ADDRESS <u>Sullivan Mo</u>	
23c. DATE SIGNED <u>8/15/50</u>		24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	
24b. DATE <u>8-17-50</u>		24c. NAME OF CEMETERY OR CREMATORY <u>LUTHERAN CEM</u>	
24d. LOCATION (City, town, or county) (State) <u>NEW HAVEN</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>L. C. Sutter</u>	
25. ADDRESS <u>New Haven</u>		DATE REC'D BY LOCAL REG. <u>8-16-50</u>	
REGISTRAR'S SIGNATURE <u>M. H. Matthews</u>		DATE <u>8-15-50</u>	

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

3360

File No. \_\_\_\_\_  
DISTRICT HEALTH OFFICE No. 4

SEP - 5 1950

RECEIVED

ADAMS

SEP 13 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 Earl Foster

Licensed Embalmer No. 3385

P. O. Address Yessleaven One

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.