

31428

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED OCT 10 1950

No. 300

10.48

BIRTH NO. _____		REG. DIST. NO. <u>210</u>		PRIMARY REG. DIST. NO. <u>3058</u>		Registrar's No. <u>173</u>	
1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).			
a. COUNTY <u>ST. CHARLES</u>		b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>ST. CHARLES</u>		c. LENGTH OF STAY (In this place) <u>30 DAYS</u>		a. STATE <u>Mo</u> b. COUNTY <u>LINCOLN</u>	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>ST. JOSEPH HOSP</u>				c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>OLD MONROE RURAL 1</u>			
d. STREET ADDRESS (If rural, give location)				4. DATE OF DEATH (Month) (Day) (Year) <u>SEPT. 27 1950</u>			
3. NAME OF DECEASED (Type or Print) (First) <u>CARRIE</u>		(Middle) <u>-</u>		(Last) <u>MENSE</u>		5. SEX <u>F</u>	
6. COLOR OR RACE <u>W</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>WIDOWED</u>		8. DATE OF BIRTH <u>MAR 9-1884</u>		9. AGE (In years last birthday) <u>66</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWOMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (State or foreign country) <u>OLD MONROE MO</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>CHRIS BURKEMPER</u>		13b. MOTHER'S MAIDEN NAME <u>BURKEMPER</u>		14. NAME OF HUSBAND OR WIFE <u>HY. MENSE DECEASED</u>			
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 ADDRESS <u>Walter Mense Old Monroe 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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Uremia + Terminal Bronchopneumonia</u>		ANTECEDENT CAUSES DUE TO (b) <u>Advanced Nephrosclerosis</u>					
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (c) <u>General Arteriosclerosis</u>		II. OTHER SIGNIFICANT CONDITIONS <u>Myocardial Damage</u>					
		<u>Chronic Bronchitis</u>				<u>4-42X</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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) m.		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>July 28, 1950</u> , to <u>Sept. 27, 1950</u> , that I last saw the deceased alive on <u>Sept. 27, 1950</u> and that death occurred at <u>9:48 a.m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>John S. Greep M.D.</u>				23b. ADDRESS <u>O'Fallons, Missouri</u>		23c. DATE SIGNED <u>3 Oct. 1950</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24b. DATE <u>SEPT. 30-1950</u>		24c. NAME OF CEMETERY OR CREMATORY <u>EMERALD CONCESSION</u>		24d. LOCATION (City, town, or county) (State) <u>OLD MONROE MO</u>	
DATE REC'D BY LOCAL REG. <u>9-30-50</u>		REGISTRAR'S SIGNATURE <u>Harris Hamilton</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Ed Keith</u>		ADDRESS <u>O'Fallon Mo.</u>	

(Licensed Embalmer's Statement on Reverse Side)

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

923

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File No. _____
DISTRICT HEALTH OFFICE No. 4

OCT - 7 1950

RECEIVED

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 E. A. Keethly

Signed _____
Student Embalmer

Licensed Embalmer No. 844

P. O. Address Fallon 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.