

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

23550

State File No.

FILED AUG 1 1951

BIRTH NO. _____ REG. DIST. NO. 172 PRIMARY REG. DIST. NO. 3034 Registrar's No. 47

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

1. PLACE OF DEATH a. COUNTY <u>Lafayette</u>		2. USUAL RESIDENCE (Where deceased lived; if institution, residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Lafayette</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Higginsville, Mo</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Higginsville</u> <u>0541</u>	
c. LENGTH OF STAY (in this place) <u>all time</u>		d. STREET ADDRESS (If rural, give location) <u>0</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION			

3. NAME OF DECEASED (Type on First) a. (First) <u>Louise</u>	b. (Middle)	c. (Last) <u>Houchen</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>7-23-51</u>
---	-------------	--------------------------	--

5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>	8. DATE OF BIRTH <u>10-19-1908</u>	9. AGE (In years last birthday) <u>42</u>	10. MONTHS <u>8</u>	11. DAYS <u>4</u>	12. HOURS <u>4</u>	13. MINUTES
----------------------	-------------------------------	---	------------------------------------	---	---------------------	-------------------	--------------------	-------------

10a. USUAL OCCUPATION (Give kind of work, duty, discharge, or status of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Higginsville, Mo.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
--	-----------------------------------	--	--

13a. FATHER'S NAME <u>Albert Kosmiski</u>	13b. MOTHER'S MAIDEN NAME <u>Elizabeth Long</u>	14. NAME OF HUSBAND OR WIFE <u>Ernest Houchen</u>
---	---	---

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. <u>488-22-1079</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Dwight Kosmiski</u>	18. ADDRESS
---	--	--	-------------

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		INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Hemorrhage</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Arteriosclerotic Hypertension</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 <u>332X</u>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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)	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 July 23, 1951, to July 22, 1951, that I last saw the deceased alive on July 22, 1951, and that death occurred at 6:30 a.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Walter Koppelman Jr. M.D.</u>	23b. ADDRESS <u>Higginsville Mo</u>	23c. DATE SIGNED <u>July 23-51</u>
---	-------------------------------------	------------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>7-25-51</u>	24c. NAME OF CEMETERY, OR CREMATORY <u>St. Mary's Catholic</u>	24d. LOCATION (City, town, or county) (State) <u>Higginsville Mo</u>
---	--------------------------	--	--

DATE REC'D BY LOCAL REG. <u>July 28-1951</u>	REGISTRAR'S SIGNATURE <u>Clayton N. Landrum</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Roy F. Wiesner</u>	ADDRESS <u>Higginsville Mo</u>
--	---	--	--------------------------------

RECEIVED

7-31-51

DISTRICT HEALTH OFFICE No. 3

District File Number _____

Date Filed 7-31-51

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 Roy F. Wiegman

Licensed Embalmer No. 2883

P. O. Address Higginsville 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.