

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

4546

State File No. ....

FILED MAR 10 1952

BIRTH NO. _____		REG. DIST. NO. <u>112</u>		PRIMARY REG. DIST. NO. <u>4429</u>		Registrar's No. <u>5</u>	
1. PLACE OF DEATH a. COUNTY <u>FRANKLIN</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>FRANKLIN</u>			
b. CITY (If outside corporate limits, write RURAL and give township) <u>NEW HAVEN MO RURAL</u>		c. LENGTH OF STAY (In this place) <u>33 1/2</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>NEW HAVEN</u>		d. STREET ADDRESS (If rural, give location) <u>0360</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Home</u>							
3. NAME OF DECEASED a. (First) <u>AMANDA</u> (Type or Print)			b. (Middle) <u>SOPHIE</u>		c. (Last) <u>LUECKER</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>FEB 7 1952</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>JAN 6 1894</u>		9. AGE (In years last birthday) <u>58</u>	if UNDER 1 YEAR Months <u>1</u> Days <u>1</u>	if UNDER 10 HRS. Hours <u>1</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>✓</u>		11. BIRTHPLACE (State or foreign country) <u>NEW HAVEN MO</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>WILLIAM DEPPERMANN</u>		13b. MOTHER'S MAIDEN NAME <u>SOPHIE HEMMINGHAW</u>		14. NAME OF HUSBAND OR WIFE <u>ADOLPH LUECKER</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>✓</u>		16. SOCIAL SECURITY NO. <u>✓</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Adolph Luecker</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>CORONARY THROMBOSIS</u>				INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u>	
* This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____					
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Acute laryngitis</u>				<u>10 da</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>4201</u>				20. AUTOPSY? YES <input 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)		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>1-28</u> , 19 <u>51</u> , to <u>2-7-</u> , 19 <u>52</u> , that I last saw the deceased alive on <u>2-1</u> , 19 <u>52</u> and that death occurred at <u>7:00</u> m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Dr. Matthews M.D.</u>				23b. ADDRESS <u>Beaufort Mo</u>		23c. DATE SIGNED <u>2/9/52</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24b. DATE <u>FEB 10 1952</u>	24c. NAME OF CEMETERY OR CREMATORY <u>PORT HUDSON LOTW CEM.</u>		24d. LOCATION (City, town, or county) (State) <u>PORT HUDSON MO</u>		
DATE REC'D BY LOCAL REG. <u>2-11-52</u>		REGISTRAR'S SIGNATURE <u>Dr. Matthews</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>L. C. Steig &amp; Son</u>		ADDRESS <u>New Haven Mo</u>	

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

360

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.....

.....  
working under my personal supervision.

Student Embalmer No.....

Signed.....

*Earl Fertig*

Signed.....

Student Embalmer

Licensed Embalmer No. *3385*

P. O. Address *Heavenly*

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.