

No. 300
10. 48

Filed JUN 4 1952

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 16049

BIRTH NO. _____ REG. DIST. NO. 119 PRIMARY REG. DIST. NO. 4193 Registrar's No. 20

1. PLACE OF DEATH a. COUNTY Gasconade		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Gasconade	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Hermann		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Hermann	
c. LENGTH OF STAY (In this place) 2 Months		0371	
d. FULL NAME OF HOSPITAL OR INSTITUTION Workman Hospital		d. STREET ADDRESS (If rural, give location) 109 W. 2nd St.	

3. NAME OF DECEASED (Type or Print)	a. (First) Rosie	b. (Middle)	c. (Last) Kirchner	4. DATE OF DEATH	(Month) 5	(Day) 19	(Year) 1952
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Jan. 3, 1876	9. AGE (In years last birthday) 76	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Hours	IF UNDER 15 MIN. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Housework	11. BIRTHPLACE (State or foreign country) Missouri	12. CITIZEN OF WHAT COUNTRY? US
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13a. FATHER'S NAME Louis Poeschel	13b. MOTHER'S MAIDEN NAME Mary Strecker	14. NAME OF HUSBAND OR WIFE Aug. H. Kirchner
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Aug. H. Kirchner, Hermann, 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, asthenia, 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) CARCINOMA OF RIGHT OVARY		9 mo.
	ANTECEDENT CAUSES Morbid 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.			

19a. DATE OF OPERATION 1-5-52	19b. MAJOR FINDINGS OF OPERATION CARCINOMA RT. OVARY WITH METASTASES 175X	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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 10-27, 1947, to 5-19, 1952, that I last saw the deceased alive on 5-18, 1952, and that death occurred at 7A m., from the causes and on the date stated above.

23a. SIGNATURE Carol T. Shaw, M.D. (Degree or title)	23b. ADDRESS Hermann, Mo.	23c. DATE SIGNED 5-20-52
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 5-21-52	24c. NAME OF CEMETERY OR CREMATORY Hermann City Cemetery Hermann	24d. LOCATION (City, town, or county) (State) Mo.
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DATE REC'D BY LOCAL REG. 5/20/52	REGISTRAR'S SIGNATURE [Signature]	25. FUNERAL DIRECTOR'S SIGNATURE [Signature]	ADDRESS Hermann, Mo.
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(Licensed Emballer's Statement on Reverse Side)

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

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 _____

Licensed Embalmer No. 3160

P. O. Address Hermann, 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.