

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

5019

State File No.

FILED FEB 16 1953

BIRTH NO. _____ REG. DIST. NO. 47 PRIMARY REG. DIST. NO. 3008 Registrar's No. 73

1. PLACE OF DEATH a. COUNTY <u>CALLOWAY</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MISSOURI</u> b. COUNTY <u>GASCONADE</u>	
b. CITY OR TOWN <u>FULTON MO</u>		c. CITY OR TOWN <u>GASCONADE COUNTY</u>	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (in this place) <u>5</u> 50 yrs		e. STREET ADDRESS (If rural, give location) <u>GASCONADE COUNTY MO 0370</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>STATE HOSPITAL NO 1</u>			

3. NAME OF DECEASED (Type or Print) <u>KATIE</u>	a. (First)	b. (Middle) <u>DOERFLINGER</u>	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year) <u>FEB 7th 1953</u>
--	------------	--------------------------------	-----------	---

5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>?</u>	8. DATE OF BIRTH <u>? Approx</u>	9. AGE (In years last birthday) <u>75</u>	IF UNDER 1 YEAR Months	IF UNDER 4 HRS. Hours	IF UNDER 15 MIN. Min.
----------------------	-------------------------------	---	----------------------------------	---	------------------------	-----------------------	-----------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>?</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>?</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>?</u>	12. CITIZEN OF WHAT COUNTRY? <u>?</u>
--	--	---	---------------------------------------

13a. FATHER'S NAME <u>?</u>	13b. MOTHER'S MAIDEN NAME <u>?</u>	14. NAME OF HUSBAND OR WIFE <u>?</u>
-----------------------------	------------------------------------	--------------------------------------

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>	16. SOCIAL SECURITY NO. <u>NONE</u>	17. INFORMANT'S SIGNATURE OR NAME <u>HOSPITAL RECORDS</u>	ADDRESS <u>FULTON MO.</u>
--	-------------------------------------	---	---------------------------

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i>	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>
	I. DISEASE OR CONDITION - DIRECTLY LEADING TO DEATH* (a) <u>Bronchial Pneumonia</u>		
	ANTECEDENT CAUSES <u>Chronic Myo-carditis.</u> <i>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</i> DUE TO (b) <u>Arterio Sclerosis</u> DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS <i>Conditions contributing to the death but not related to the disease or condition causing death.</i>		<u>42218</u>	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	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) 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 Oct 1, 1953, to 2/7th/53, that I last saw the deceased alive on 2/7th/53, 1953, and that death occurred at 10: A m., from the causes and on the date stated above.

23a. SIGNATURE <u>Robert Roberts</u> (Degree or title)	23b. ADDRESS <u>FULTON Missouri.</u>	23c. DATE SIGNED <u>Feb 7-1953</u>
--	--------------------------------------	------------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE <u>2-10-53</u>	24c. NAME OF CEMETERY OR CREMATORY <u>anatomical Board</u>	24d. LOCATION (City, town, or county) (State) <u>Columbia MO</u>
---	--------------------------	--	--

DATE REC'D BY LOCAL REG. <u>Feb 10-1953</u>	REGISTRAR'S SIGNATURE <u>Marilyn Lawrence</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>J.O. Roberts</u>	ADDRESS <u>Columbia MO</u>
---	---	--	----------------------------

(Licensed Embalmer's Statement on Reverse Side)

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

0143 2

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.....
Signature of Student Embalmer

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.