

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **10425**

LED APR 7 1953

BIRTH NO. _____ REG. DIST. NO. 172 PRIMARY REG. DIST. NO. 3034 Registrar's No. 23

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

1. PLACE OF DEATH a. COUNTY LAFAYETTE		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MISSOURI b. COUNTY LAFAYETTE	
b. CITY (If outside corporate limits, write RURAL and give township) HIGGINSVILLE		c. CITY (If outside corporate limits, write RURAL and give township) HIGGINSVILLE	
c. LENGTH OF STAY (in this place) 20YR.		d. STREET ADDRESS (If rural, give location) 301 WEST 29TH STREET	
d. FULL NAME OF HOSPITAL OR INSTITUTION			

3. NAME OF DECEASED (Type or Print) a. (First) MARY b. (Middle) GOTTFRIET c. (Last) GOTTFRIET			4. DATE OF DEATH (Month) (Day) (Year) 3 29 53		
5. SEX F	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) SINGLE	8. DATE OF BIRTH JAN. 21, 1873	9. AGE (In years last birthday) 80	10. 2 8
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEKEEPER		10b. KIND OF BUSINESS OR INDUSTRY HOME		11. BIRTHPLACE (City and State or Foreign Country) WAVERLY, MISSOURI	
12. CITIZEN OF WHAT COUNTRY? USA					

13a. FATHER'S NAME ANTON GOTTFRIET		13b. MOTHER'S MAIDEN NAME ELIZABETH KILLIN		14. NAME OF HUSBAND OR WIFE	
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.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS WILLIAM HOLT HIGGINSVILLE	

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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute pulmonary embolus			INTERVAL BETWEEN ONSET AND DEATH 46 hrs
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Cardiac decompensation chronic			2-3 yrs.
		DUE TO (c) Arteriosclerosis generalised			DK.
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Rheumatoid Arthritis (deformans)			20 yrs.
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 4221			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) 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 Jan 15, 1950, to Mar 29, 1953, that I last saw the deceased alive on Mar 29, 1953, and that death occurred at 7:00 a. m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Edwin H. Hanson M.D.		23b. ADDRESS Higginville Mo.		23c. DATE SIGNED 3/31/53	
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24b. DATE 3-31-53		24c. NAME OF CEMETERY OR CREMATOR CITY	
				24d. LOCATION (City, town, or county) (State) HIGGINSVILLE, Mo.	

DATE REC'D BY LOCAL REG. April 7, 1953		REGISTRAR'S SIGNATURE Clayton H. Landrum		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS HIGGINSVILLE, MO.	
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(Licensed Embalmer's Statement on Reverse Side)

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 Farrell J. Hoelzer

Licensed Embalmer No. 4358

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.