

FILED APR 28 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

12763

State File No.

BIRTH NO. _____ REG. DIST. NO. 230 PRIMARY REG. DIST. NO. 4344 Registrar's No. 75

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY (If outside corporate limits, write RURAL and give OR TOWN <u>MCKITTRICK</u>)	c. LENGTH OF STAY (in this place) <u>6 yrs</u> (township)	c. CITY (If outside corporate limits, write RURAL and give township) <u>McKITTRICK</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION _____		d. STREET ADDRESS (If rural, give location) _____	

3. NAME OF DECEASED (Type or Print) a. (First) <u>CLARA</u>		b. (Middle) _____	c. (Last) <u>KARL</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>April 24 1954</u>		
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5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>Nov 14 1871</u>	9. AGE (In years last birthday) <u>83</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (State or foreign country) <u>Bridgeport Mo</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>
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13a. FATHER'S NAME <u>CARL NECK</u>	13b. MOTHER'S MAIDEN NAME <u>HENRIETTA GUENTHER</u>	14. NAME OF HUSBAND OR WIFE <u>JACOB KARL</u>	
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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>Mrs W. F. Schmidt</u> ADDRESS <u>McKITTRICK Mo</u>	
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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, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary Occlusion - Infarction</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Atherosclerotic Heart Disease</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		INTERVAL BETWEEN ONSET AND DEATH <u>60 hours</u> <u>4+ years</u>
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19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION _____	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) _____
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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? _____
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22. I hereby certify that I attended the deceased from January, 1954, to Apr. 24, 1954, that I last saw the deceased alive on Apr. 24, 1954, and that death occurred at 5:00 P. M., from the causes and on the date stated above.

23a. SIGNATURE <u>John P. Ryan</u> (Degree or title) _____	23b. ADDRESS <u>Mo</u>	23c. DATE SIGNED <u>4-26-54</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	24b. DATE <u>4/27/1954</u>	24c. NAME OF CEMETERY OR CREMATORY <u>LOUTRE ISLAND CEM.</u>	24d. LOCATION (City, town, or county) (State) <u>McKITTRICK R70 Mo</u>
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DATE REC'D BY LOCAL REG. <u>April 27, 1954</u>	REGISTRAR'S SIGNATURE <u>Mrs. Eunice Bush</u> <u>432-0</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Hugost, Lemmer</u> ADDRESS <u>HERMANN Mo</u>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

JAN 2 1957

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.

Signed.....
Student Embalmer

Student Embalmer No.....

Signed.....
August L. Lerner

Licensed Embalmer No. *3160*

P. O. Address *Herrmann Men*

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.