

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

31375

State File No. \_\_\_\_\_

BIRTH NO. _____		REG. DIST. NO. <u>274</u>		PRIMARY REG. DIST. NO. <u>2052</u>		Registrar's No. <u>348</u>			
1. PLACE OF DEATH a. COUNTY <u>rettis</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>rettis</u>					
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Sedalia</u>		c. LENGTH OF STAY (in this place) <u>16 Days</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural white Township</u>					
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Bothwell Hospital</u>				d. STREET ADDRESS (If rural, give location) <u>Ionia Route #1</u>					
3. NAME OF DECEASED (Type or Print) a. (First) <u>Frederick</u>			b. (Middle) <u>Christian</u>		c. (Last) <u>Harms</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Sept 16th 1954</u>		
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, <u>Married</u>		8. DATE OF BIRTH <u>Dec. 20th 1871</u>		9. AGE (In years last birthday) <u>82</u> if under 1 year: Months <u>8</u> Days <u>26</u> if under 2 wks: Hours <u>   </u> Mins. <u>   </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Agriculture</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Mora Missouri R #1</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13a. FATHER'S NAME <u>Dietrick Harms</u>			13b. MOTHER'S MAIDEN NAME <u>Katherine Holtz</u>			14. NAME OF HUSBAND OR WIFE <u>Anna Harms</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Mrs Anna Harms</u>				ADDRESS <u>Cole Camp Mo</u>	
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) <u>Cerebral Vascular accident</u>						INTERVAL BETWEEN ONSET AND DEATH <u>15 days</u>	
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Arterio Sclerosis</u>							
		DUE TO (c) _____							
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Barbiturates</u>						<u>15 yrs</u>	
18a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>331 X</u>						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)		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>9/3</u> , 19 <u>54</u> , to <u>9/16/54</u> , 19 <u>   </u> , that I last saw the deceased alive on <u>9/16</u> , 19 <u>54</u> , and that death occurred at <u>1:15 P.m.</u> , from the causes and on the date stated above.									
23a. SIGNATURE <u>Thomas J. Hoptman, M.D.</u>				23b. ADDRESS <u>Sedalia Mo</u>				23c. DATE SIGNED <u>9/17/54</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Sept 20th 1954</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Memorial park</u>		24d. LOCATION (City, town, or county) (State) <u>Sedalia Mo</u>			
DATE REC'D BY LOCAL REG. <u>9-18-54</u>		REGISTRAR'S SIGNATURE <u>Lavera Coontz, Deputy</u>			25. FUNERAL DIRECTOR'S SIGNATURE <u>E. L. Eickhoff</u>		ADDRESS <u>Cole Camp Mo</u>		

(Licensed Embalmer's Statement on Reverse Side)

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

FEB 10 1958

AUG 16 1955

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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 E. L. Eickhoff

Licensed Embalmer No. 730

P. O. Address Cole Camp 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.