

FILED JUL 8 - 1955

# THE DIVISION OF HEALTH OF MISSOURI STANDARD CERTIFICATE OF DEATH

State File No. 18233

BIRTH NO. REG. DIST. NO. 119 PRIMARY REG. DIST. NO. 5443 Registrar's No. 19

|   |                                  |  |   |  |   |  |   |
|---|----------------------------------|--|---|--|---|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>GASCONADE</b>   |                                  |  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>a. STATE <b>Mo</b> b. COUNTY <b>GASCONADE</b>   |   |  |   |
| b. CITY OR TOWN <b>RURAL-ROARK TWP</b> c. LENGTH OF STAY (in this place) <b>99RS</b>  |                                  |  |   | c. CITY (If outside corporate limits, write RURAL and give township)<br>OR TOWN <b>RURAL-ROARK TWP</b> 370.  |   |  |   |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <b>5 mi. S. of HERMANN</b>  |                                  |  |   | d. STREET ADDRESS (If rural, give location)<br><b>5 mi. S. of HERMANN</b>  |   |  |   |
| 3. NAME OF DECEASED<br>(Type or Print) a. (First) <b>AMALIA</b> b. (Middle) <b>—</b> c. (Last) <b>DUFNER</b>  |                                  |  | 4. DATE OF DEATH (Month) (Day) (Year)<br><b>MAY 31-1955</b> |  |   |  |   |
| 5. SEX<br><b>FEMALE</b>   | 6. COLOR OR RACE<br><b>WHITE</b> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)<br><b>WIDOWED</b>                               | 8. DATE OF BIRTH<br><b>Nov-7-1874</b>                       |  | 9. AGE (in years last birthday)<br><b>80</b>  | 10. UNDER 1 YEAR<br><input checked="" type="checkbox"/> Months           | 11. UNDER 10 HRS.<br><input checked="" type="checkbox"/> Days |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |                                  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Housework</b>       |  | 11. BIRTHPLACE (City and State or Foreign Country)<br><b>HERMANN Mo</b>             |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>US</b>                     |
| 13a. FATHER'S NAME<br><b>WILLIAM FRICKE</b>   |                                  |  | 13b. MOTHER'S MAIDEN NAME<br><b>AGATHA DUFFNER</b>          |  | 14. NAME OF HUSBAND OR WIFE<br><b>CHAS DUFNER SR</b>                                |  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>NO</b>   |                                  |  | 16. SOCIAL SECURITY NO.<br><b>None</b>                      |  | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS<br><b>MRS BERNARD APPRILL RFD HERMANN</b> |  |   |
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.   |                                  |  |   | MEDICAL CERTIFICATION<br>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>MYOCARDIAL INFARCTION</b><br><br>ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) <b>ARTERIO SCLEROSIS</b><br>DUE TO (c) <b>HYPERTENSION</b><br><br>II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death.<br><b>4201</b> |   |  |   |
| 19a. DATE OF OPERATION  |                                  | 19b. MAJOR FINDINGS OF OPERATION   |   |  |   | 20. AUTOPSY?<br>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) (Min.)  |                                  | 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 <b>12-1</b> , 19 <b>53</b> , to <b>MAY 31</b> , 19 <b>55</b> that I last saw the deceased alive on <b>MAY 31</b> , 19 <b>55</b> , and that death occurred at <b>12:30 P.m.</b> , from the causes and on the date stated above. |                                  |  |   |  |   |  |   |
| 23a. SIGNATURE (Degree or title)<br><b>George M. Workman M.D.</b>   |                                  |  |   | 23b. ADDRESS<br><b>HERMANN, MO</b>   |   | 23c. DATE SIGNED<br><b>6-2-55</b>  |   |
| 24a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  |                                  | 24b. DATE<br><b>6/3/55</b>   |   | 24c. NAME OF CEMETERY OR CREMATORY<br><b>ST GEORGES CEMETERY</b>   |   | 24d. LOCATION (City, town, or county) (State)<br><b>HERMANN, MO</b>      |   |
| DATE REC'D BY LOCAL REG.<br><b>6-2-55</b>   |                                  | REGISTRAR'S SIGNATURE<br><b>Delma Gerken</b>   |   | 25. FUNERAL DIRECTOR'S SIGNATURE<br><b>August Dufner</b>   |   | ADDRESS<br><b>HERMANN MO</b>   |   |

(Licensed Embelmer's Statement on Reverse Side)

FEB 20 1956

SEP 25 1956

### 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

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.