No. 100
10.48

FILED OCT 3 - 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 29577

BIRTH NO. _____ REG. DIST. NO. 137 PRIMARY REG. DIST. NO. 3023 Registrar's No. 31

1. PLACE OF DEATH
a. COUNTY: Henry
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Clinton
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Clinton General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Mo
b. COUNTY: Henry
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Urich Rural
d. STREET ADDRESS (If rural, give location): 0 4 0

3. NAME OF DECEASED (Type or Print)
a. (First): Babette
b. (Middle):
c. (Last): Meyer

4. DATE OF DEATH (Month) (Day) (Year): 9 24-19[illegible]

5. SEX: Female
6. COLOR OR RACE: white
7. ~~MARRIED, NEVER MARRIED,~~ WIDOWED, ~~DIVORCED (Specify)~~
8. DATE OF BIRTH: Dec 30 1869
9. AGE (In years last birthday): 86
If under 1 year: Months / Days / Hours / Minutes

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housekeeping
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (City and State or Foreign Country): Bayern Germany
12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13a. FATHER'S NAME: John Getz
13b. MOTHER'S MAIDEN NAME: Kunigunde Daush
14. NAME OF HUSBAND OR WIFE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: None
17. INFORMANT'S SIGNATURE OR NAME: L. F. Meyer
ADDRESS:

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, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hypostatic Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 3 days

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Intramedullary fracture left Hip (one week)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

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 ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug 5, 1955, *to* Sept 23, 1955, *that I last saw the deceased alive on* Sept 23, 1955, *and that death occurred at* 6:30 A m., *from the causes and on the date stated above.*

23a. SIGNATURE: R. S. Hallingquist (Degree or title) M. D.
23b. ADDRESS: Clinton Mo.
23c. DATE SIGNED: 9/26/55

24a. BURIAL, CREMATION, REMOVAL (Specify):
24b. DATE: Sept. 26-1955
24c. NAME OF CEMETERY OR CREMATORY: Urich
24d. LOCATION (City, town, or county) (State): Urich. Rural Mo.

DATE REC'D BY LOCAL REG.: 9-26-55
REGISTRAR'S SIGNATURE: Florence Adair
25. FUNERAL DIRECTOR'S SIGNATURE: W. J. Brown. Urich Mo.
ADDRESS:

(Licensed Embalmer's Statement on Reverse Side)

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

JAN 3 1956 NHP

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 R. R. Kenney

Licensed Embalmer No. 3099

P. O. Address Clinton 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.