

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. **32771**

BIRTH NO. _____		REG. DIST. NO. <b>118</b>		PRIMARY REG. DIST. NO. <b>5441</b>		Registrar's No. <b>30</b>	
<b>I. PLACE OF DEATH</b> a. COUNTY <b>Gasconade</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>Gasconade</b>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Rural Third Creek</b>		c. LENGTH OF STAY (in this place) <b>63 yrs.</b>		c. CITY OR TOWN <b>Owensville</b>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Farm Home</b>				e. STREET ADDRESS (If rural, give location) <b>Owensville Rt. 2</b>			
<b>3. NAME OF DECEASED</b> (Type or Print) <b>Theodore</b>			a. (First) <b>Theodore</b>		b. (Middle) <b>Drusch</b>		c. (Last) <b>Drusch</b>
<b>5. SEX</b> <b>male</b>		<b>6. COLOR OR RACE</b> <b>white</b>		<b>7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)</b> <b>widowed</b>		<b>8. DATE OF BIRTH</b> <b>Nov. 25, 1866</b>	
<b>9. AGE</b> (In years last birthday) <b>88</b>		<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>farmer</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>farming</b>		<b>11. BIRTHPLACE</b> (City and State or Foreign Country) <b>Bem, Mo.</b>	
<b>13a. FATHER'S NAME</b> <b>Charles Drusch</b>		<b>13b. MOTHER'S MAIDEN NAME</b> <b>Wilhelmine Drusch</b>		<b>14. NAME OF HUSBAND OR WIFE</b> <b>Minnie Schaefferkoetter</b>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>no</b>		<b>16. SOCIAL SECURITY NO.</b> <b>none</b>		<b>17. INFORMANT'S SIGNATURE OR NAME</b> <b>John Drusch</b> <b>Owensville, Mo.</b>			
<b>18. CAUSE OF DEATH</b> Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.				<b>MEDICAL CERTIFICATION</b> <b>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*</b> (a) <b>Chronic Myocardial Degeneration</b> <b>5405</b>  <b>ANTECEDENT CAUSES</b> Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. <b>DUE TO (b) Arteriosclerosis, Advanced</b> <b>5405</b>  <b>DUE TO (c) 4221</b>  <b>II. OTHER SIGNIFICANT CONDITIONS</b> Conditions contributing to the death but not related to the disease or condition causing death. <b>Bilateral Cataracts, Mature</b> <b>145</b>			
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>21a. ACCIDENT SUICIDE HOMICIDE</b> (Specify)		<b>21b. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21c. (CITY, TOWN, OR TOWNSHIP)</b> (COUNTY) (STATE)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) m.		<b>21e. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from</b> <b>5-14, 1955</b> , to <b>10-25, 1955</b> , that I last saw the deceased alive on <b>10-24, 1955</b> , and that death occurred at <b>3:30 a.m.</b> , from the causes and on the date stated above.							
<b>23a. SIGNATURE</b> (Deceased or title) <b>Paula Grunert</b>				<b>23b. ADDRESS</b> <b>Owensville, Mo.</b>		<b>23c. DATE SIGNED</b> <b>10-25-55</b>	
<b>24a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>burial</b>		<b>24b. DATE</b> <b>10-28-1955</b>		<b>24c. NAME OF CEMETERY OR CREMATORY</b> <b>Third Creek Cem.</b>		<b>24d. LOCATION (City, town, or county)</b> (State) <b>near Owensville, Mo.</b>	
<b>DATE REC'D BY LOCAL</b> <b>October 28, 1955</b>		<b>REGISTRAR'S SIGNATURE</b> <b>Mrs. Marvin Jappmy</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <b>W.H. Winter</b>		<b>ADDRESS:</b> <b>OWENSVILLE</b>	

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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 Ma....., Student Embalmer No..... working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed Malcolm H. W. Winters.....

Licensed Embalmer No. 38

P. O. Address OWENS

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.