

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH
State File No. **765**
 BIRTH NO. _____ REG. DIST. NO. **77** PRIMARY REG. DIST. NO. **5305** Registrar's No. **2**

1. PLACE OF DEATH a. COUNTY COLE		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY CODE	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN JEFFERSON CITY, MO.		c. CITY OR TOWN JEFFERSON CITY	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. LENGTH OF STAY (in this place) LIFE		e. STREET ADDRESS (If rural, give location) R # 3 LIBERTY TOWNSHIP	
d. FULL NAME OF HOSPITAL OR INSTITUTION R. R. 3 LIBERTY TOWNSHIP			

3. NAME OF DECEASED (Type or Print) a. (First) HENRY b. (Middle) _____ c. (Last) BERNSKOETTER			4. DATE OF DEATH (Month) (Day) (Year) JAN. 16, 1956		
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED	8. DATE OF BIRTH JULY 4, 1872	9. AGE (In years last birthday) 83	IF UNDER 1 YEAR Months 6 Days 12
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) TAOS, MO.		12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME HENRY BERNSKOETTER		13b. MOTHER'S MAIDEN NAME ELIZABETH SCHWALLER		14. NAME OF HUSBAND OR WIFE EMMA PYKE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT'S SIGNATURE OR NAME ADDRESS VICTOR BERNSKOETTER J. C. MO	

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) Myocardial Failure ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. Atherosclerotic Heart Disease DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 4200			INTERVAL BETWEEN ONSET AND DEATH
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19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		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 checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from **Jan 19 55** to **Dec 13 55**, that I last saw the deceased alive on **Dec 13, 1955**, and that death occurred at **4:00** m., from the causes and on the date stated above.

23a. SIGNATURE A Osman MD		(Degree or title) MD		23b. ADDRESS 507 E. High		23c. DATE SIGNED 1-16-56	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 1/19/56		24c. NAME OF CEMETERY OR CREMATORY ST. FRANCIS XAVIER		24d. LOCATION (City, town, or county) (State) TAOS, MO.	

DATE REC'D BY LOCAL REG. 17 Jan 1956		REGISTRAR'S SIGNATURE R. P. Davis MD-MR		25. FUNERAL DIRECTOR'S SIGNATURE Sylvester Gulle		ADDRESS J. C. MO.	
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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.....
Signature of Student Embalmer

Signed..... *Sylvester Quille*

Licensed Embalmer No. *4321*

P. O. Address *Jefferson*

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.