

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

9990

State File No.

FILED APR 16 1956

BIRTH NO. _____ REG. DIST. NO. 257 PRIMARY REG. DIST. NO. 5880 Registrar's No. 23

1. PLACE OF DEATH a. COUNTY Osage		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY Marion	
b. CITY OR TOWN Linn, Mo. Rural		c. CITY OR TOWN Brinktown, Mo.	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) 3 days		e. STREET ADDRESS (If rural, give location) Miller Twp.	
d. FULL NAME OF HOSPITAL OR INSTITUTION Minnor Rest Home			

3. NAME OF DECEASED (Type or Print)	a. (First) Fritz	b. (Middle) none	c. (Last) Luebbert	4. DATE OF DEATH (Month) (Day) (Year) April 9, 1956.
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH March 24, 1866.	9. AGE (In years last birthday) 90 Months 0 Days 15	IF UNDER 1 YEAR IF UNDER 14 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) Osage County, Mo.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Ben Luebbert	13b. MOTHER'S MAIDEN NAME Mary Kloeppel	14. NAME OF HUSBAND OR WIFE Bertha Kehr.
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME Phillip Luebbert, Jefferson City, Mo	ADDRESS
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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		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary occlusion		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hypertension DUE TO (c) Generalized Arterio Sclerosis		
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 <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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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?
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22. I hereby certify that I attended the deceased from June 1, 1955, to 4-9-56, 1956, that I last saw the deceased alive on 4-8, 1956, and that death occurred at 10:15 Am., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) W. L. McManally M.D.	23b. ADDRESS Jefferson City Mo	23c. DATE SIGNED
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 4/11/56	24c. NAME OF CEMETERY OR CREMATORY Brinktown Cemetery	24d. LOCATION (City, town, or county) (State) Brinktown, Mo.
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DATE REC'D BY LOCAL REG. Apr 14-1956	REGISTRAR'S SIGNATURE T. A. Submitter	25. FUNERAL DIRECTOR'S SIGNATURE W. C. Cunningham	ADDRESS Vienna, Mo.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

300
48

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was em
by me, or by, Student Embalmer No.....
working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *W. P. Cunningham*.....

Licensed Embalmer No. *36*.....

P. O. Address *Summ*.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.