

THE DIVISION OF HEALTH OF MISSOURI STANDARD CERTIFICATE OF DEATH

FILED JUN 19 1956

State File No. **21042**

BIRTH NO. _____		REG. DIST. NO. 171		PRIMARY REG. DIST. NO. 5639		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY Lafayette				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Lafayette			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Rural - Washington				c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Rural - Washington 0540			
d. FULL NAME OF HOSPITAL OR INSTITUTION Cover & Hugginsville				d. STREET ADDRESS (If rural, give location) 4 mi West of Higginsville			
3. NAME OF DECEASED (Type or Print)		a. (First) August		b. (Middle) William		c. (Last) Molte	
5. SEX male		6. COLOR OR RACE white		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married		4. DATE OF DEATH (Month) (Day) (Year) June 4 1956	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farming		10b. KIND OF BUSINESS OR INDUSTRY land owner		8. DATE OF BIRTH July 15, 1893		9. AGE (If years last birthday) 62 # UNDER 1 YEAR Months Days # UNDER 100 HRS Min.	
11a. FATHER'S NAME Frederick W. Molte		11b. MOTHER'S MATHEN NAME Mary Hiegenbaum		11c. NAME OF HUSBAND OR WIFE Cather Knollenberg Molte		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 440-42-4753		17. INFORMANT'S SIGNATURE OR NAME Mrs. Cather Molte - Higginsville, Mo. 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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Thrombosis ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) 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. Cardiac decompensation				INTERVAL BETWEEN ONSET AND DEATH 2 years	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION 4200				20. AUTOPSY? YES ☐ NO ☒	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (i.e., 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 ☐ NOT WHILE AT WORK ☐		21f. HOW DID INJURY OCCUR? _____			
22. I hereby certify that I attended the deceased from April , 19 56 , to June 4 , 19 56 , that I last saw the deceased alive on June 2 , 19 56 , and that death occurred at _____ m., from the causes and on the date stated above.							
23a. SIGNATURE J. H. Koppensprung (Degree or title) M.D.		23b. ADDRESS Higginsville Mo		23c. DATE SIGNED June 9-56			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE June 9, 1956		24c. NAME OF CEMETERY OR CREMATORY Mayview		24d. LOCATION (City, town, or county) (State) Mo.	
DATE REC'D BY LOCAL REG. June 9, 1956		REGISTRAR'S SIGNATURE Emma Davidson		25. FUNERAL DIRECTOR'S SIGNATURE David Dickhof ADDRESS Higginsville, Mo.			

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.....

working under my personal supervision.

Signed.....
Student Embalmer

Signed.....

Student Embalmer No.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.