

14393

 THE DIVISION OF HEALTH OF MISSOURI  
 STANDARD CERTIFICATE OF DEATH

FILED APR 18 1957

STATE FILE NUMBER

 Registration District No. 316 Primary Registration District No. 6070 Registrar's No. 118

1. PLACE OF DEATH a. COUNTY <u>St. Francois</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Francois</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Knob Lick, Mo.</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			c. CITY OR TOWN <u>Knob Lick, Mo.</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION			d. STREET ADDRESS <u>0940</u> (If outside, give location) <u>0</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Robert</u> Last <u>Center</u>			4. DATE OF DEATH Month <u>April</u> Day <u>7</u> Year <u>1957</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 16 1875</u>	9. AGE (In years last birthday) <u>81</u> IF UNDER 1 YEAR: Months <u>10</u> Days <u>21</u> Hours <u>21</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Miner</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City, and state or country) <u>0 Co. Middlebrook, Mo. St. Francois</u>	
13. FATHER'S NAME <u>Robert Center</u>			14. MOTHER'S MAIDEN NAME <u>Lucy Scooler</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Mrs. William Center</u> Address <u>Knob Lick, Mo.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Toxemia + Bowel Obstruction</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Carcinomatosis</u> DUE TO (c) <u>Primary Carcinoma Sigmoid Colon</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (n) <u>153X</u>					INTERVAL BETWEEN ONSET AND DEATH <u>1 wk.</u> <u>sw. whe.</u> <u>unknown</u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <u>2</u>			20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			20c. TIME OF INJURY Hour <u>7:35</u> Month <u>Apr</u> Day <u>7</u> Year <u>57</u> a. m. <u>p. m.</u>		
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <u>3-4-57</u> to <u>4-7-57</u> and last saw <u>him</u> alive on <u>4-6-57</u> Death occurred at <u>7:35</u> p. m. on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Doctor or Title) <u>Harwin L. Euler M.D.</u>			22b. ADDRESS <u>Farmington Mo.</u>		22c. DATE SIGNED <u>4-8-57</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>April 9, 1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Union Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Knob Lick Mo.</u>
24. FUNERAL DIRECTOR <u>C. H. Cozart</u> ADDRESS <u>Farmington, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>Apr. 8, 1957</u>		26. REGISTRAR'S SIGNATURE <u>Esther Rudloff</u>	

(Licensed Embalmer's Statement on Reverse Side)

Health, &amp; Welfare Public Service

S. 300 1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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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 *Donald H. Wenzel*

Licensed Embalmer No. *460*

P. O. Address *Festa, D*

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.