

Dept. Health,
, & Welfare
S. Public
Health Service

FILED JUN 10 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

570 17725

STATE FILE NUMBER

Registration District No. 164 Primary Registration District No. 3032 Registrar's No. _____

V. S. 300
Rev. 1-57

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1. PLACE OF DEATH a. COUNTY <u>Johnson</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Johnson</u> <input checked="" type="checkbox"/>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Warrensburg</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Warrensburg, 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 <u>Ross Nursing Home</u>		Length of stay in lb <u>4 yr.</u>	d. STREET ADDRESS (If outside, give location) <u>508 West King Street</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Harry</u> Middle _____ Last <u>Mohler</u>			4. DATE OF DEATH Month <u>June</u> Day <u>1st</u> Year <u>1957</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-22-1872</u>		9. AGE (In years last birthday) <u>85</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>General</u>	11. BIRTHPLACE (City and state or country) <u>Covington Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13a. FATHER'S NAME <u>Johnnie Mohler</u>		13b. MOTHER'S MAIDEN NAME <u>Mary Ann Miller</u>		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. -	17. INFORMANT Address _____		
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>Chronic Nephritis</u>					INTERVAL BETWEEN ONSET AND DEATH <u>6 mo.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Arteriosclerosis 592X</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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 _____ Month _____ Day _____ Year _____ a.m. _____ p.m. _____					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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>Jan. 1954</u> to <u>6-1-57</u> and last saw ^{her} him alive on <u>5-31-57</u> Death occurred at <u>6:30 P.M.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>R. Lee Cooper</u> (Degree or title) <u>M.D.</u>			22b. ADDRESS <u>Warrensburg, Missouri.</u>		22c. DATE SIGNED <u>6-2-57</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>6-6-57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mineral Creek Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Leeton Mo.</u>	
24. FUNERAL DIRECTOR <u>W. B. Haminger</u>		ADDRESS <u>Warrensburg, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>June 8 1957</u>	26. REGISTRAR'S SIGNATURE <u>Savannah Cutchfield</u> <u>by Earl West Deputy</u>	

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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1961 6 1 7081

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 J.P. Bauninger

Licensed Embalmer No. 3377
P. O. Address Warrensburg, Mo.

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.