THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

32520
STATE FILE NUMBER

FILED SEP 20 1957

Registration District No. 383 Primary Registration District No. 5658 Registrar's No. 95

1. PLACE OF DEATH
a. COUNTY Lawrence
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Vineyard — Inside Limits Yes ☐ No ☒
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Home of daughter — Length of stay in 1b 8 yrs

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Lawrence
c. CITY OR TOWN Stotts City — Inside Limits Yes ☐ No ☒
d. STREET ADDRESS (If outside, give location) Near Stotts City — Reside on Farm Yes ☒ No ☐

3. NAME OF DECEASED (Type or print) First: Minnie Middle: Last: Jung
4. DATE OF DEATH Month Day Year: 9 - 9 - 1957
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 12 - 26 - 1883
9. AGE (In years last birthday): 73
IF UNDER 1 YEAR Months Days; IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housekeeper
10b. KIND OF BUSINESS OR INDUSTRY: Housekeeping
11. BIRTHPLACE (City and state or country): Lawrence County, Mo.
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: William Rathmann
14. MOTHER'S MAIDEN NAME: Louise Rathmann
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service): none
16. SOCIAL SECURITY NO.: none
17. INFORMANT: Mrs. Bertha Kleine Address: Stotts City, Mo.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Respiratory Failure — INTERVAL BETWEEN ONSET AND DEATH: 6 hrs.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Cor Pulmonale — 2 weeks
DUE TO (c) Mitral Stenosis — unknown
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Tumor Mass of Intestine 410X
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
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 June 1955 to Sept 9/57 and last saw her alive on Sept 9/57
Death occurred at 2:15 P m on the date stated above; and to the best of my knowledge, from the causes stated.
22a. SIGNATURE Harold E. Geage (Degree or title) DO
22b. ADDRESS Mt Vernon Mo
22c. DATE SIGNED 9/10/57

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 9 - 11 - 57
23c. NAME OF CEMETERY OR CREMATORY: Zion Evangelical cemetery
23d. LOCATION (City, town, or county) (State): 8 mi. S.W. Mt. Vernon, Mo.
24. FUNERAL DIRECTOR: H. D. Fossett ADDRESS: Mt. Vernon, Mo.
25. DATE RECD. BY LOCAL REG.: 9-13-57
26. REGISTRAR'S SIGNATURE: Cecil Hendricks

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Doctor, coroner, etc. may 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.

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 ...me....., Student Embalmer No.....

working under my personal supervision.

Student.....
Signature of Student Embalmer

Signed H D Fossett

Licensed Embalmer No. 22

P. O. Address Mt Vern

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.