

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

39978
STATE FILE NUMBER

FILED NOV 25 1957

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 1101-D

| | | | |
|--|--|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>Greene</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Douglas</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Springfield</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | c. CITY OR TOWN <u>Drury</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Mercy Hosp</u> Length of stay in lb <u>6 mo</u> | | d. STREET ADDRESS (If outside, give location) <u>Douglas Co</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>Alois</u> Middle <u>Moritz</u> Last <u>Moritz</u> | | | 4. DATE OF DEATH Month <u>Nov.</u> Day <u>13</u> Year <u>1957</u> |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</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>Oct. 3, 1869</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u> | 9. AGE (In years last birthday) <u>88</u> IF UNDER 1 YEAR: Months _____ Days _____ Hours _____ Mins. _____ |
| 11. BIRTHPLACE (City and state or country) <u>Beraria, Germany</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13a. FATHER'S NAME <u>Unknown</u> | | 13b. MOTHER'S MAIDEN NAME <u>Unknown</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> | | 17. INFORMANT Address <u>Herman Moritz - Drury, 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>Generalized Arterio-sclerosis</u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>4</u> |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____ | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>4500</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 _____ Month, Day, Year _____ a.m. _____ p.m. _____ | | | |
| 20d. INJURY OCCURRED WHILE AT <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>Aug 6 - 1957</u> to <u>Nov 13, 1957</u> and last saw her alive on <u>Nov 19, 1957</u> Death occurred at <u>6:20 p.</u> m on the date stated above; and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE (Degree or title) <u>Blanchette J. M.D.</u> | | 22b. ADDRESS <u>Springfield Mo</u> | 22c. DATE SIGNED <u>11-14-57</u> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE <u>11/18/1957</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Blanche Cemetery</u> | 23d. LOCATION (City, town, or county) (State) <u>Douglas County, Mo</u> |
| 24. FUNERAL DIRECTOR ADDRESS <u>Barber F. Home, 7th Grove, Mo</u> | | 25. DATE RECD. BY LOCAL REG. <u>11-18-57</u> | 26. REGISTRAR'S SIGNATURE <u>Edith Williamson</u> |

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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.

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 *George Stoff*

Licensed Embalmer No. *3161*

P. O. Address *Mt. Hope, 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.