

Health, Welfare, Public Service

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 causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

FILED FEB 19 1958

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-004421
STATE FILE NUMBER

Registration District No. 27 Primary Registration District No. 5078 Registrar's No. 16

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| 1. PLACE OF DEATH a. COUNTY <u>BATES</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Bates</u> | |
| b. CITY OR TOWN <u>Montrose</u> TOWNSHIP (only) <u>TP</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | c. CITY OR TOWN <u>Montrose</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>None.</u> | | d. STREET ADDRESS (If outside, give location) <u>50 yr.</u> | |

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|--|---------------------------|---|--|---|--|--|
| 3. NAME OF DECEASED (Type or print) First <u>EURA</u> Middle <u>LORE</u> Last <u>KRETZINGER</u> | | | 4. DATE OF DEATH <u>JAN 30 - 58</u> Month <u>Jan</u> Day <u>30</u> Year <u>58</u> | | | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Apr. 28 - 1874</u> | 9. AGE (In years last birthday) <u>83</u> | IF UNDER 1 YEAR Months <u>9</u> Days <u>2</u> | IF UNDER 24 HRS. Hours <u></u> Min. <u></u> |

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|--|--|-----------------------------------|---|---|---|---|--|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (City and state or country) <u>Henry Co, Mo.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Samuel Drake</u> | | | 14. MOTHER'S MAIDEN NAME <u>KATHERIN HUNT</u> | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. <u>—</u> | | 17. INFORMANT <u>Charles Kretzinger</u> Address <u>Appleton City Mo.</u> | | |

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|---|--|---|--|
| 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>Cerebral hemorrhage</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>10 days</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>331X</u> | | | |

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|---|--|---|--|---|--|--|---------------------|------------------|
| 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 _____ a. m. _____ p. m. _____ | | | | | | | | |
| 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 <u>Appleton City</u> | | | COUNTY <u>Bates</u> | STATE <u>Mo.</u> |

21. I attended the deceased from 10:30 p.m. 58 to 30 Jan 58 and last saw her/him alive on 29 Jan 58.
Death occurred at 10:30 p.m. m on the date stated above; and to the best of my knowledge, from the causes stated.

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|---|-----------------------------------|-----------------------------------|
| 22a. SIGNATURE <u>Willard M. [Signature]</u> (Degree or title) | 22b. ADDRESS <u>Appleton City</u> | 22c. DATE SIGNED <u>31 Jan 58</u> |
|---|-----------------------------------|-----------------------------------|

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|---|-------------------------|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | 23b. DATE <u>2-1-58</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Brookgrass Union</u> | 23d. LOCATION (City, town, or county) <u>Montrose, Mo.</u> |
| 24. FUNERAL DIRECTOR <u>Dr. [Signature]</u> ADDRESS <u>Appleton City</u> | | 25. DATE RECD. BY LOCAL REG. <u>Feb. 1-1958</u> | 26. REGISTRAR'S SIGNATURE <u>Hendell Kurray</u> |

11-0

Licensed Embalmer (Statement on Reverse Side)

8561 7 318

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, Student Embalmer No.....
working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *Oscau Eckhoff*

Licensed Embalmer No. *39*

P. O. Address *Appleton*

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.