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

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

FILED MAR 11 1958

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-004840
STATE FILE NUMBER

Registration District No. 73 Primary Registration District No. 5291 Registrar's No. 39

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1. PLACE OF DEATH
a. COUNTY: Clay
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: Liberty — Inside Limits Yes X No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: Old Fellows Home — Length of stay in 1b: 7 mo

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mo. b. COUNTY: Lafayette
c. CITY OR TOWN: Napoleon 0540 — Inside Limits Yes ☐ No X
d. STREET ADDRESS (If outside, give location): Clay 3 mi So. — Reside on Farm Yes X No ☐

3. NAME OF DECEASED (Type or print): First: Augusta Middle: Last: Berlekamp
4. DATE OF DEATH: Month: Feb Day: 21 Year: 1958
5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED X DIVORCED ☐
8. DATE OF BIRTH: Oct 30-1864
9. AGE (In years last birthday): 93
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): housewife
10b. KIND OF BUSINESS OR INDUSTRY: Agriculture
11. BIRTHPLACE (City and state or country): St. Charles County Mo
12. CITIZEN OF WHAT COUNTRY?: U.S.A.
13. FATHER'S NAME: William Kronshage
14. MOTHER'S MAIDEN NAME: Elizabeth Lammeier
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: no.
17. INFORMANT: Wilbert Schlapper — Address: Napoleon 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): Encephalomalacia — INTERVAL BETWEEN ONSET AND DEATH
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): 332X
19. WAS AUTOPSY PERFORMED? YES ☐ NO X

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 1957 to Feb 21, 58 and last saw her alive on 2/18/58
Death occurred at 9:20 p m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: Wm H Gordon (Degree or title)
22b. ADDRESS: Liberty Mo
22c. DATE SIGNED: 2/22/58

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: Feb. 24-58
23c. NAME OF CEMETERY OR CREMATORY: Napoleon C & R Cemetery
23d. LOCATION (City, town, or county) (State): Napoleon Mo.
24. FUNERAL DIRECTOR: Ralph O Jones — ADDRESS: Odessa Mo
25. DATE RECD. BY LOCAL REG.: 2-28-58
26. REGISTRAR'S SIGNATURE: Mabel Graham

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
MAR 3 1958
CLAY CO.
HEALTH CENTER

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 Ralph O. Jones

Licensed Embalmer No. 46

P. O. Address Odessa

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.