

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED APR 3 1958

STATE FILE NUMBER

Registration District No. 53 Primary Registration District No. _____ Registrar's No. 245

1. PLACE OF DEATH a. COUNTY <u>CAPE GIRARDEAU</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>CAPE</u>	
b. CITY OR TOWN <u>CAPE GIRARDEAU</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>ALLENVILLE</u> <u>0160</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>SOUTH EAST MISSOURI HOSP.</u> Length of stay in lb <u>3 DAYS</u>		d. STREET ADDRESS (If outside, give location) _____ Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>LOUISE</u> Last <u>GINTER</u>			4. DATE OF DEATH Month <u>MARCH</u> Day <u>26</u> Year <u>1958</u>		
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN. 23, 1890</u>	9. AGE (In years last birthday) <u>68</u>	IF UNDER 1 YEAR Months <u>2</u> Days <u>3</u> Hours _____ Min. _____
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>Lixville, Missouri</u>	

13a. FATHER'S NAME <u>William Deimund</u>		13b. MOTHER'S MAIDEN NAME <u>MINNIE PUTMAN</u>		14. NAME OF HUSBAND OR WIFE <u>GEORGE E. GINTER</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>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>GEORGE E. GINTER - Alleville, 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>Subarachnoid Hemorrhage</u> DUE TO (b) <u>(Massive -</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (c) <u>Arterio sclerotic hypertension</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH _____		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			<u>330X</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 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 COUNTY STATE	

21. I attended the deceased from March 24th, 1958 to March 25th, 1958 last saw her alive on March 25, 1958
Death occurred at Southeast Hospital - 1:15A m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Alfred M. Patin M.D.</u>		22b. ADDRESS <u>714 Broadway, Cape Girardeau, Mo.</u>		22c. DATE SIGNED <u>3/28/58</u>	
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>3-27-1958</u>		23c. NAME OF CEMETERY OR CREMATORY <u>ALLENVILLE CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>ALLENVILLE, Mo.</u>	
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24. FUNERAL DIRECTOR ADDRESS <u>BISPINGHOFF FUNERAL HOME - CHAFFEE, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>March 31, 1958</u>		26. REGISTRAR'S SIGNATURE <u>MAV Homer C. Cooper</u>	
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Health, welfare, public service, 000-570, Doctor, coroner, etc. MUST USE ONLY STANDARD MEMORANDUM. All diseases in Part I must be causally related.

APR 9 1958

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 *Jack T. Lummell*
Licensed Embalmer No. *4473*
P. O. Address. *Chaffee, 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.