

Health, Welfare
Public
Service
620
300
1-57

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-028717
STATE FILE NUMBER

FILED SEP 15 1958 Registration District No. 115-116 Primary Registration District No. 3030 Registrar's No. 227

1. PLACE OF DEATH a. COUNTY <u>Franklin</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Franklin</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Washington</u>		c. CITY OR TOWN <u>New Haven</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Francis Hosp.</u>		d. STREET ADDRESS (If outside, give location)	
Length of stay in lb <u>1 wk</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>ANNA</u> Middle <u>MARY</u> Last <u>Augustin</u>			4. DATE OF DEATH Month <u>Aug.</u> Day <u>30</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>Aug. 27, 1877</u>	9. AGE (In years last birthday) <u>81</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>3</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
-------------------------	----------------------------------	---	--	--	--	--

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 <u>Housekeeping</u>	11. BIRTHPLACE (City and state or country) <u>Washington, Mo.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
---	--	--	---

13a. FATHER'S NAME <u>FRANK KRAFT</u>	13b. MOTHER'S MAIDEN NAME <u>CHRISTINA HILKE</u>	14. NAME OF HUSBAND OR WIFE
--	---	-----------------------------

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>UNKNOWN</u>	17. INFORMANT <u>ANDREW AUGUSTIN</u> Address <u>NEW HAVEN, 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>Cerebro-vascular hemorrhage</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 wk.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Arterio-sclerotic C.V.-R disease</u>	
	DUE TO (c) <u>Old age</u> <u>442 X</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>none</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <u>2</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 <u></u> Month, Day, Year <u></u> a.m. <u></u> p.m. <u></u>	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 <u></u> STATE <u></u>
---	--	--	--

21. I attended the deceased from <u>August 22, 1958</u> and last saw her alive on <u>Aug. 30, 1958</u> Death occurred at <u>4 A.M.</u> on the date stated above; and to the best of my knowledge from the causes stated.

22a. SIGNATURE <u>R. W. Boggs, MD</u> (Degree or title)	22b. ADDRESS <u>Washington Mo.</u>	22c. DATE SIGNED <u>9/31/58</u>
--	---------------------------------------	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>9/1/58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Assumption Catholic Cem.</u>	23d. LOCATION (City, town, or county) (State) <u>New Haven Mo.</u>
--	----------------------------	---	---

24. FUNERAL DIRECTOR <u>L. C. Fertig & Son</u> ADDRESS <u>New Haven Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>9/2/58</u>	26. REGISTRAR'S SIGNATURE <u>J. H. Steinhilber, Jr. M.D.</u>
--	---	---

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

1958 2 ADM

OCT 21 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 me....., Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed Carl C. [Signature].....

Licensed Embalmer No. 3385.....

P. O. Address New Haven, Ct......

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.