Health, & Welfare Public Service

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THE DIVISION OF HEALTH OF MISSOURI

# STANDARD CERTIFICATE OF DEATH

58-033356
STATE FILE NUMBER

FILED OCT 3 1958 Registration District No. 174 Primary Registration District No. 3035 Registrar's No. 79

1. PLACE OF DEATH
a. COUNTY Lafayette
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Lexington — Inside Limits Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) Memorial — Length of stay in 1b 59 days

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Lafayette
c. CITY OR TOWN 0541 Higginsville, Mo — Inside Limits Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location) 705 W 25th — Reside on Farm Yes [ ] No [X]

3. NAME OF DECEASED (Type or print) First Mabel Middle Peacock Last Froeschle
4. DATE OF DEATH Month Sept Day 22 Year 1958

5. SEX Female 1
6. COLOR OR RACE White
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH 2-10, 1901
9. AGE (In years last birthday) 57 — 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 Home
11. BIRTHPLACE (City and state or country) Corder, Mo. 0
12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME Frank Peacock
13b. MOTHER'S MAIDEN NAME Elizabeth Schrier
14. NAME OF HUSBAND OR WIFE Karl K. Frosechle

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no
16. SOCIAL SECURITY NO. none
17. INFORMANT Karl Froeschle — Address Higginsville, 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) Multiple Myeloma — INTERVAL BETWEEN ONSET AND DEATH 2 years.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)
DUE TO (c) 203X
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)
19. WAS AUTOPSY PERFORMED? YES [ ] NO [X] 2

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 July 22, 1958, to Sept. 22, 1958 and last saw her alive on 9-21-58
Death occurred at 1:58 AM m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) H. E. Fulkerson M.D. 0
22b. ADDRESS Higginsville Mo.
22c. DATE SIGNED 9-23-58

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE 2-23-1958
23c. NAME OF CEMETERY OR CREMATORY City
23d. LOCATION (City, town, or county) (State) Higginsville, Mo.

24. FUNERAL DIRECTOR F. A. Hoefer — ADDRESS Higginsville, Mo.
25. DATE RECD. BY LOCAL REG. 9-27-58
26. REGISTRAR'S SIGNATURE Minnie E. Eachelsen

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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.

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OCT 6 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 Ernest K. Hoefer

Licensed Embalmer No. 4801

P. O. Address Higginsville, 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.