Health, Welfare Public Service

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1-57

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-000893
STATE FILE NUMBER

REC'D JAN 13 1959 Registration District No. 119 Primary Registration District No. 5443 Registrar's No. 1

1. PLACE OF DEATH
a. COUNTY: GASCONADE
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only): ROARK — Inside Limits: Yes ☐ No ☑
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): FRENE VALLEY HOME — Length of stay in 1b: 1 YEAR

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mo. b. COUNTY: GASCONADE
c. CITY OR TOWN: HERMANN — Inside Limits: Yes ☑ No ☐
d. STREET ADDRESS (If outside, give location): 319 WEST 6TH ST. — Reside on Farm: Yes ☐ No ☑

3. NAME OF DECEASED (Type or print): First: EMMA Middle: Last: OBENHAUS

4. DATE OF DEATH: Month 1 Day 2 Year 59

5. SEX: FEMALE **6. COLOR OR RACE**: WHITE **7. MARRIED** ☐ **NEVER MARRIED** ☐ **WIDOWED** ☑ **DIVORCED** ☐

8. DATE OF BIRTH: FEB. 20, 1866 **9. AGE** (In years last birthday): 92 — 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**: —

11. BIRTHPLACE (City and state or country): HERMANN, Mo. **12. CITIZEN OF WHAT COUNTRY?**: U.S.

13a. FATHER'S NAME: ERNEST GAEBLER **13b. MOTHER'S MAIDEN NAME**: EMMA SEEN **14. NAME OF HUSBAND OR WIFE**: CHAS. OBENHAUS

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.: NONE **17. INFORMANT**: CHARLES OBENHAUS Address: HERMANN, Mo.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

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): Auriculo-ventricular block — INTERVAL BETWEEN ONSET AND DEATH: 21 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Arteriosclerotic heart disease — 10 years
DUE TO (c):
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): 4280

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

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 6-21-50 to 1-2-59 and last saw her/him alive on 12-29-58
Death occurred at 5:50 A m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Carrel T. Shaw, M.D. **22b. ADDRESS**: Hermann, Mo. **22c. DATE SIGNED**: 1-2-59

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL **23b. DATE**: 1-5-59 **23c. NAME OF CEMETERY OR CREMATORY**: HERMANN CEMETERY **23d. LOCATION** (City, town, or county) (State): HERMANN Mo.

24. FUNERAL DIRECTOR: HUGO H. BLUMER **ADDRESS**: HERMANN Mo. **25. DATE RECD. BY LOCAL REG.**: 1-3-59 **26. REGISTRAR'S SIGNATURE**: Delma Uffelman

(Licensed Embalmer's Statement on Reverse Side)

JAN 19 19

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 Roger W. Blumer

Licensed Embalmer No. 5055

P. O. Address Hermann, 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.