Health, Welfare & Public Service

300
1-57

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

FILED JAN 29 1959

59-004129
STATE FILE NUMBER

Registration District No. 328 Primary Registration District No. ~~3073~~ Registrar's No. 5

1. PLACE OF DEATH
a. COUNTY: SCOTT
b. CITY OR TOWN: CHAFFEE — Inside Limits: Yes ☐ No ☑
c. FULL NAME OF HOSPITAL OR INSTITUTION: RFD #1 — Length of stay in 1b:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MO b. COUNTY: SCOTT
c. CITY OR TOWN: CHAFFEE — Inside Limits: Yes ☐ No ☑
d. STREET ADDRESS (If outside, give location): RFD #1 — Reside on Farm: Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First: SYLVESTER Middle: JOHN Last: WRAHAHN

4. DATE OF DEATH: Month: JAN. Day: 17 Year: 1959

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

8. DATE OF BIRTH: SEPT 28-1958

9. AGE (In years last birthday): 3 — IF UNDER 1 YEAR: Months: 3 Days: 27 — IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (City and state or country):
12. CITIZEN OF WHAT COUNTRY?:

13a. FATHER'S NAME: SYLVESTER WRAHAHN
13b. MOTHER'S MAIDEN NAME: ANNA ELFRANK
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):
16. SOCIAL SECURITY NO.: —
17. INFORMANT: Sylvester Wrahahn — Address: RFD #1 CHAFFEE MO

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Cardiac Arrest	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)	Congenital Mitral Insufficiency	3 month 27 day
DUE TO (c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): 7545

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 20 Sept 58, to 17 Jan 59 and last saw ~~him~~ him alive on 17 Jan 59
Death occurred at 5:00 p.m. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: R. Trubble (Degree or title): MD **22b. ADDRESS**: Chaffee Mo **22c. DATE SIGNED**: 19 Jan 59

23a. BURIAL, CREMATION, REMOVAL (Specify): B **23b. DATE**: Jan 19-1959 **23c. NAME OF CEMETERY OR CREMATORY**: St Ambrose Cem. **23d. LOCATION** (City, town, or county) (State): Chaffee Mo

24. FUNERAL DIRECTOR: Stubblefield Funeral Home **ADDRESS**: CHAFFEE MO. (Licensed Embalmer) **25. DATE RECD. BY LOCAL REG.**: Jan 20-59 **26. REGISTRAR'S SIGNATURE**: Mustard Bingling Leff

(See Reverse Side)

Doctor, Coroner, etc. must use only surface ink or ribbon typewriter if possible. Enter diseases in Part I that are the immediate cause of death. All diseases in Part I must be causally related.

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 Eugene L. Stubbs

Licensed Embalmer No. 5012

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.