Health, Welfare Public Service

300
1-57

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-004130
STATE FILE NUMBER

FILED JAN 29 1959

Registration District No. 328 Primary Registration District No. 6118 Registrar's No. 6

1. PLACE OF DEATH
a. COUNTY: SCOTT
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: SYLVANIA TWNSHP — Inside Limits: Yes ☐ No ☒
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: R. F. D. #1 ORAN — Length of stay in Hospital: 3 Days

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

3. NAME OF DECEASED (Type or print): First: REGINA Middle: MARGARET Last: WALTER

4. DATE OF DEATH: Month: JAN. Day: 12 Year: 1959

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: NOV. 2 1881

9. AGE (In years last birthday): 77 — 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): HOUSE WIFE

10b. KIND OF BUSINESS OR INDUSTRY: IN OWN HOME

11. BIRTHPLACE (City and state or country): NEW HAMBURG, MO.

12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13a. FATHER'S NAME: FRANK BLES

13b. MOTHER'S MAIDEN NAME: ROSALIA GROJEAN

14. NAME OF HUSBAND OR WIFE: FRANCIS WALTER

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.: ?

17. INFORMANT: MRS. GEORGE POBST Address: ORAN, 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): Uremia — INTERVAL BETWEEN ONSET AND DEATH: 4 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Acute Renal Failure — 5 days
DUE TO (c): Cerebral Vascular Accident — 2 wks
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): 331 X

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 Jan, 1957 to 12 Jan 59 and last saw her alive on 12 Jan 59
Death occurred at 4:30A. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): R. E. Tribble MD

22b. ADDRESS: Chaffee Mo

22c. DATE SIGNED: 14 Jan 59

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE: JAN. 14 1959

23c. NAME OF CEMETERY OR CREMATORY: NEW GUARDIAN ANGELS

23d. LOCATION (City, town, or county) (State): ORAN MO.

24. FUNERAL DIRECTOR: Carl J. Smith — ADDRESS: ORAN, MO.

25. DATE RECD. BY LOCAL REG.: Jan 20 - 59

26. REGISTRAR'S SIGNATURE: Mrs Fred Bisplinghoff

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 Earl J. Smith

Licensed Embalmer No. 2676

P. O. Address Owen, 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.