

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-006547

STATE FILE NUMBER

FILED MAR 9 1959 Registration District No. 256 Primary Registration District No. 4388 Registrar's No. 2

1. PLACE OF DEATH a. COUNTY Osage		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Osage	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Chamois		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Chamois 0760 Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		Length of stay in 1b life	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First MIDDLE Last OTTO PAUL GIESING			4. DATE OF DEATH Month Day Year Mar. 1, 1959
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 19, 1891
9. AGE (In years last birthday) 67		IF UNDER 1 YEAR Months Days Hours Min. 9 12	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming retired		10b. KIND OF BUSINESS OR INDUSTRY selfemployed	11. BIRTHPLACE (City and state or country) Missouri 0
12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME John Giesing	
13b. MOTHER'S MAIDEN NAME Caroline Gosen		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) No		16. SOCIAL SECURITY NO. None	17. INFORMANT Address Mrs. A. B. Schuth, Chamois, Mo
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Embolism</i>			INTERVAL BETWEEN ONSET AND DEATH 5 min.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <i>Coronary arteriosclerotic disease</i>			6 to 12 mo.
DUE TO (c) <i>Post-Anterior Myocardial infarction</i>			6 mo.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>moderate Hypertension</i>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 2
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 Month, Day, Year a.m. p.m.			
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 STATE
21. I attended the deceased from <i>9-2-58</i> to <i>3-1-59</i> and last saw <sup>him</sup> alive on <i>3-1-59</i> . Death occurred at <i>12:35</i> p. m. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <i>F. B. Farnsworth, D.O.</i>		22b. ADDRESS Chamois, Mo.	22c. DATE SIGNED 3/4/59
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 3/4/1959	23c. NAME OF CEMETERY OR CREMATORY Catholic Cemetery	23d. LOCATION (City, town, or county) (State) Chamois, Mo.
24. FUNERAL DIRECTOR ADDRESS Clyde Morton, Linn, Mo.		25. DATE RECD. BY LOCAL REG. 3/4/59	26. REGISTRAR'S SIGNATURE <i>Josephine Schieder</i>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

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 *James M. Morton* .....

Licensed Embalmer No. *4125* .....

P. O. Address *Levin* .....

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.