Health, & Welfare Public Service

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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-012893
STATE FILE NUMBER

FILED APR 30 1958 Registration District No. 119 Primary Registration District No. 5943 Registrar's No. 18

1. PLACE OF DEATH
a. COUNTY GASCONADE
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only) ROARK TWP — 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 9 MONTHS

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) 217 E. 2ND ST — Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print) First FRITZ Middle Last KIDERLEN
4. DATE OF DEATH Month APRIL Day 19 Year 1959
5. SEX MALE
6. COLOR OR RACE CAU.
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH JAN. 29-1874
9. AGE (In years last birthday) 85 — 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) FARMER
10b. KIND OF BUSINESS OR INDUSTRY FARMING
11. BIRTHPLACE (City and state or country) CASE Mo
12. CITIZEN OF WHAT COUNTRY? U.S.
13a. FATHER'S NAME JOHN KIDERLEN
13b. MOTHER'S MAIDEN NAME ANNA MOELFENTER
14. NAME OF HUSBAND OR WIFE SADIE KIDERLEN
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 ROBERT KIDERLEN Address HERMANN Mo

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.

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) Cerebro-vascular thrombosis — 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) Cerebral arteriosclerosis — 10 yrs
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Arteriosclerotic heart disease 332X
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 11-10-48 to 4-19-59 and last saw her/him alive on 4-18-59
Death occurred at 9:30 A m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Carl T. Shull, MD (Degree or title)
22b. ADDRESS Hermann, Mo.
22c. DATE SIGNED 4-20-59

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
23b. DATE 4/21/59
23c. NAME OF CEMETERY OR CREMATORY LOUTRE ISLAND CEMETERY
23d. LOCATION (City, town, or county) (State) R7D McKITTRICK Mo
24. FUNERAL DIRECTOR HUGH H. BLOMER ADDRESS HERMANN Mo
25. DATE RECD. BY LOCAL REG. 4-21-59
26. REGISTRAR'S SIGNATURE Delma Uffelman

(Licensed Embalmer's Statement on Reverse Side)

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. Blanc

Licensed Embalmer No. 5055

P. O. Address Vernon, N

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.