

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-014381

Health,
Welfare
Public
Service
Div.

300
-57

FILED MAY 13 1959 Registration District No. 275 Primary Registration District No. 3053 STATE FILE NUMBER Registrar's No. 76

1. PLACE OF DEATH a. COUNTY <u>Polk</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Cass</u>	
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only) <u>Kolla</u>		c. CITY OR TOWN <u>Owensville</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Polk Hosp</u>		d. STREET ADDRESS (If outside, give location) <u>Route # 2</u>	
Length of stay in 1b <u>18 Hrs</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last <u>RONNIE Dale GEORGE</u>			4. DATE OF DEATH Month Day Year <u>MAY 4 1959</u>		
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5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 3 1959</u>	9. AGE (In years last birthday) IF UNDER 1 YEAR Months Day Hours Min. <u>1</u>	IF UNDER 24 HRS
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>INFANT</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	11. BIRTHPLACE (City and state or country) <u>Cuba Mo.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Joe George</u>	13b. MOTHER'S MAIDEN NAME <u>Rosie Kosarik</u>	14. NAME OF HUSBAND OR WIFE <u>No</u>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>No</u>	17. INFORMANT <u>Joe George</u>	Address <u>RT. # 2 Owensville Mo</u>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Hemorrhage</u> <u>and atherosclerotic atherosclerosis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Cause unknown</u> DUE TO (c) <u>Cause unknown</u>		INTERVAL BETWEEN ONSET AND DEATH <u>21 hours.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>7710</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
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20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	20d. INJURY OCCURRED WHILE AT <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
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21. I attended the deceased from <u>5-3-59</u> to <u>5-4-59</u> and last saw <u>him</u> alive on <u>5-4-59</u> Death occurred at <u>10:20 A.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE <u>[Signature]</u> (Degree or title)	22b. ADDRESS <u>102 Viola Mo</u>	22c. DATE SIGNED <u>5-5-59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>5-5-1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>City Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Owensville Mo</u>
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24. FUNERAL DIRECTOR <u>Norman C. Hoener</u>	ADDRESS <u>Cuba, Mo</u>	25. DATE RECD. BY LOCAL REG. <u>May 5, 1959</u>	26. REGISTRAR'S SIGNATURE <u>Dadnie L. Stoll</u>
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

Date Filed January 12, 1959

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 Norman O. Hoer

Licensed Embalmer No. 4673
P. O. Address

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.