Health, Welfare Public Service

30

300
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-020698
STATE FILE NUMBER

FILED JUN 24 1959 Registration District No. 70 Primary Registration District No. _____ Registrar's No. 29

1. PLACE OF DEATH
a. COUNTY: Clark
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: Sea Moines Inf — Inside Limits Yes ☐ No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: — Length of stay in 1b

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri b. COUNTY: Clark
c. CITY OR TOWN: — Inside Limits Yes ☐ No ☐
d. STREET ADDRESS (If outside city, give location): Sea Moines Inf — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First: Minnie Middle: Marie Last: Biggerstaff
4. DATE OF DEATH: Month 6 Day 4 Year 1959
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 3-16-1877
9. AGE (In years last birthday): 82 — 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): At Home
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (City and state or country): Hamburg Germany
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Frederick Buhrkuhl
14. MOTHER'S MAIDEN NAME: Mary Radenslaen
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.: —
17. INFORMANT: Orson P. Biggerstaff Address: Alexandria 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): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 24 hrs
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 331X
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 6-3-59, to 6-4-59 and last saw her alive on 6-4-59
Death occurred at 2-am m on the date stated above; and to the best of my knowledge, from the causes stated.
22a. SIGNATURE: S. H. Channing (Degree or title) Do
22b. ADDRESS: Kahoka Mo
22c. DATE SIGNED: 6-6-59
23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 6-6-59
23c. NAME OF CEMETERY OR CREMATORY: Kahoka Cemetery
23d. LOCATION (City, town, or county) (State): Kahoka Mo.
24. FUNERAL DIRECTOR: J. J. Karle ADDRESS: Kahoka Mo.
25. DATE RECD. BY LOCAL REG.: 6/17-59
26. REGISTRAR'S SIGNATURE: H. Bridges

(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 eml

by me, or by ....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed Fred J Karle

Licensed Embalmer No 102.

P. O. Address Kahoka M

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (F
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.