

DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS AUG 4 1959

4191

31 59-024700  
~~4191~~ STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY <b>Gasconade</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo</b> b. COUNTY <b>Gasconade</b>				
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>Gasconade</b>		Length of stay in 1b <b>32 yrs</b>		c. CITY OR TOWN <b>Gasconade</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location)			Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>HARRISON</b> Middle <b>MARTIN</b> Last <b>BAKER</b>				4. DATE OF DEATH Month <b>July</b> Day <b>28</b> Year <b>1959</b>				
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Cau.</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH	9. AGE (last birthday) <b>70</b>		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer Foreman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Boat Industry</b>		11. BIRTHPLACE (City and state or country) <b>Cooper Hill, Mo</b>		12. CITIZEN OF WHAT COUNTRY <b>US</b>		
13a. FATHER'S NAME <b>Unkown</b>			13b. MOTHER'S MAIDEN NAME <b>Unkown</b>		14. NAME OF HUSBAND OR WIFE <b>Elsie Baker</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>491-24-0154</b>		17. INFORMANT Address <b>Mrs. Nola Reinholz, Gasconade, Mo</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION</b>							INTERVAL BETWEEN ONSET AND DEATH <b>1 HOUR</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) <b>HYPERTENSIVE HEART DISEASE</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)					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
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.)				
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____								
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 <b>1953</b> to <b>7-28-59</b> and last saw her <b>6-19-59</b> Death occurred at <b>245 p</b> on the date stated above, and to the best of my knowledge, from the causes stated.				her him				
22a. SIGNATURE (Degree or title) <b>George M. Workman MD.</b>				22b. ADDRESS <b>HERMANN, MO</b>		22c. DATE SIGNED <b>7-30-59</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <b>7/31/1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Gasconade Cemetery</b>		23d. LOCATION (City, town, or county) <b>Gasconade</b>		Mo	(State)	
24. FUNERAL DIRECTOR <b>Hugo H. Blumer</b>			ADDRESS <b>Hermann, Mo</b>	25. DATE RECD. BY LOCAL REG. <b>7-30-59</b>	26. REGISTRAR'S SIGNATURE <b>Welma Uffelman</b>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

AUG 1 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 \_\_\_\_\_ or by \_\_\_\_\_ Student Embalmer No. \_\_\_\_\_ working under my personal supervision.

Student \_\_\_\_\_ Signature of Student Embalmer

Signed Hugo H. Hermann Licensed Embalmer No. 3160

P. O. Address Hermann, Md

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to do so 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.