

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS AUG 12 1959

59-025779

Registration District No. 774 Primary Registration District No. 3035 Registrar's No. 68

STATE FILE NUMBER

| | | | | | | | | |
|---|---|---|--|---|---|---|---|---|
| 1. PLACE OF DEATH a. COUNTY Lafayette | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri COUNTY Lafayette | | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Lexington | | Length of stay in 1b 6 days | | c. CITY OR TOWN Odessa | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Lexington Memorial | | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) 305 W. Otway | | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First Amanda Middle Sophie Last Werner | | | | 4. DATE OF DEATH Month July Day 19 Year 1959 | | | | |
| 5. SEX female | 6. COLOR OR RACE white | 7. Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 7-19-1919 | 9. AGE (last birthday) 62 | 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) housewife | | | 10b. KIND OF BUSINESS OR INDUSTRY upholstering | | 11. BIRTHPLACE (City and state or country) St. Charles, Mo. | | 12. CITIZEN OF WHAT COUNTRY USA | |
| 13a. FATHER'S NAME Edward Telgemeier | | | 13b. MOTHER'S MAIDEN NAME Caroline Engelege | | | 14. NAME OF HUSBAND OR WIFE Martin O. Werner | | |
| 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: Martin O. Werner, Odessa, 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) Acute Coronary Thrombosis | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 2 days | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | DUE TO (b) Old | | DUE TO (c) | | 6 wks | | |
| 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 checked="" 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 checked="" 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 July 17, 1959 to July 19, 1959 and last saw her/him alive on July 18, 1959 Death occurred at 8:45 A.m. on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | | |
| 22a. SIGNATURE Joe W Ward (Degree or title) | | | | 22b. ADDRESS Lexington, Mo. | | | 22c. DATE SIGNED 7, 22, 59 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) burial | 23b. DATE 7-21-59 | 23c. NAME OF CEMETERY OR CREMATORY Odessa Cemetery | | 23d. LOCATION (City, town, or county) (State) Odessa, Lafayette, Mo. | | | | |
| 24. FUNERAL DIRECTOR Ralph O. Jones, Odessa, Mo. | | | 25. DATE RECD. BY LOCAL REG. 8-1-59 | | 26. REGISTRAR'S SIGNATURE Thomas E. Fitch | | | |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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 Ralph O Jones

Licensed Embalmer No. 460

P.O. Address Odessa

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.