

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-025796

FILED VS AUG 11 1958

Registration District No. 283 Primary Registration District No. 5647 Registrar's No. 91

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Lawrence</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Lawrence</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Freistatt</u>		Length of stay in 1b <u>3 years</u>		c. CITY OR TOWN <u>McKernon</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Crest View Rest Home</u>				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>Rt 1 McKernon</u>	
3. NAME OF DECEASED (Type or print) First <u>Minnie</u> Middle <u>L.</u> Last <u>Bartelsmeyer</u>				4. DATE OF DEATH Month <u>8</u> - Day <u>2</u> - Year <u>1959</u>			
5. SEX <u>Fe</u>	6. COLOR OR RACE <u>W</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>2-1-1874</u>	9. AGE (last birthday) <u>85</u>	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) <u>housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Lawrence, Co., Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>John Henry Horstmann</u>			13b. MOTHER'S MAIDEN NAME <u>Christina Koeman</u>		14. NAME OF HUSBAND OR WIFE <u>Louie Bartelsmeyer</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. _____		17. INFORMANT <u>Alvin Bartelsmeyer St Louis, Mo.</u> Address _____		
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>Organic Brain Damage</u> DUE TO (b) <u>Cerebral Arteriosclerosis</u> <u>and generalized arteriosclerosis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. _____							INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>fracture rt hip 1956</u>					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 <u>Aug 8/1947</u> to <u>8/12/59</u> and last saw her alive on <u>8/12/59</u> Death occurred <u>8:25 P.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>[Signature]</u> (Degree or title)				22b. ADDRESS <u>Net Vernon Mo</u>		22c. DATE SIGNED <u>8/13/59</u>	
23a. BURIAL CREATION OR REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>8-5-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Maple Grove Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Hoberg, Mo.</u>		
24. FUNERAL DIRECTOR <u>Max L. Forett</u> ADDRESS <u>McKernon, Mo.</u>			25. DATE RECD. BY LOCAL REG. <u>8-4-59</u>		26. REGISTRAR'S SIGNATURE <u>Cecil Hendricks</u>		

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

Max L Fossell

Licensed Embalmer No. 4252

P. O. Address Milwaukee

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