

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-028115

FILED VS AUG 25 1959

Registration District No. 632 Primary Registration District No. _____ Registrar's No. 55

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Bollinger</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Bollinger</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Lutesville, Mo</u>		c. CITY OR TOWN <u>Marble Hill</u>	
Length of stay in 1b <u>6mo</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Bond Nursing Home</u>		d. STREET ADDRESS (If outside, give location)	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>BERNARD</u> Middle <u>L.</u> Last <u>KLASING</u>			4. DATE OF DEATH Month <u>Aug.</u> Day <u>20</u> Year <u>1959</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 31, 1871</u>	9. AGE (last birthday) <u>87</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>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (City and state or country) <u>Vandalia, Ill.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>
13a. FATHER'S NAME <u>unknown</u>		13b. MOTHER'S MAIDEN NAME <u>unknown</u>		14. NAME OF HUSBAND OR WIFE <u>Ora KLASING</u>		
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>Ora KLASING Marble Hill 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>Medullary Failure</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Progressive</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Thrombotic Encephalomalacia</u>		<u>Chronic</u>	
DUE TO (c) <u>Arteriosclerosis</u>		<u>Chronic</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Bronchopneumonia. Inanition</u>		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.) <u>none</u>	
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 May 28, 1957 to Aug. 19 and last saw her alive on Aug 19, 1959
Death occurred at 12:30 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>William J. Freitas D.O.</u>		22b. ADDRESS <u>Lutesville, Mo</u>		22c. DATE SIGNED <u>8-20-59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE <u>8-22-1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Lorimier Cem.</u>	23d. LOCATION (City, town, or county) (State) <u>Cape Girardeau, Mo</u>	
24. FUNERAL DIRECTOR <u>Gene Ward Lutesville, Mo</u>		25. DATE RECD. BY LOCAL REG. <u>8/24/59</u>	26. REGISTRAR'S SIGNATURE <u>Mrs. Buford Crader</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 Herbert Liley, Student Embalmer No. 579

working under my personal supervision.

Student Herbert Liley
Signature of Student Embalmer

Signed R. O. Laird

Licensed Embalmer No. 4538

P. O. Address Jackson, Mo.

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.