

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-028531

FILED VS AUG 24 1959

Registration District No. 82 Primary Registration District No. 3017 Registrar's No. 118

STATE FILE NUMBER

DED

1. PLACE OF DEATH a. COUNTY Cooper				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Cooper									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Boonville			Length of stay in 1b 66 Yrs.		c. CITY OR TOWN Bunceton,		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>						
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Joseph Hospital				Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) -----		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Henry Middle Hoerl. Last Hoerl.				4. DATE OF DEATH Month August Day 21 Year 1959									
5. SEX Male		6. COLOR OR RACE White		7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH June 9, 1882		9. AGE (last birthday) 77		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>		IF UNDER 24 HR Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer				10b. KIND OF BUSINESS OR INDUSTRY Own Farm		11. BIRTHPLACE (City and state or country) Germany		12. CITIZEN OF WHAT COUNTRY USA					
13a. FATHER'S NAME Paulas Hoerl				13b. MOTHER'S MAIDEN NAME Margaret Elizabeth Hager				14. NAME OF HUSBAND OR WIFE -----					
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. -----		17. INFORMANT Address Mrs. Annie Baslee, Sedalia, 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) Bilateral Atypical Pneumonia										INTERVAL BETWEEN ONSET AND DEATH 3 days			
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) Arterio-sclerotic heart disease								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 Aug 19-59 to Aug 21-59 and last saw him alive on Aug 21-59 Death occurred at 7:10 P. on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE Dr. Decker (Degree or title) MD				22b. ADDRESS Boonville Mo				22c. DATE SIGNED 8/22/59 (State)					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Aug. 23rd 1959		23c. NAME OF CEMETERY OR CREMATORY Clarks Fork				23d. LOCATION (City, town, or county) Cooper County, Mo.					
24. FUNERAL DIRECTOR Goodman & Boller, Boonville, Mo. ADDRESS				25. DATE RECD. BY LOCAL REG. 8/22/59		26. REGISTRAR'S SIGNATURE [Signature]							

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 Wm. Wood

Licensed Embalmer No. 4539

P. O. Address Boonville, Mo.

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.