

R.I. DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-029654

FILED VS SEP 15 1959 171

Registration District No. _____ Primary Registration District No. 4266 Registrar's No. 70 STATE FILE NUMBER

DED

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|---|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Lafayette | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Lafayette | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Wellington, Clay | | Length of stay in lb 79 yrs. | | c. CITY OR TOWN Wellington | | (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 type="checkbox"/> No <input checked="" 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 WILLIE Middle F. Last SOENDKER | | | | 4. DATE OF DEATH Month September Day 2 Year 1959 | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | | 8. DATE OF BIRTH 7/31/1873 | 9. AGE (last birthday) 86 | 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) Retired Farmer | | | 10b. KIND OF BUSINESS OR INDUSTRY Farming | 11. BIRTHPLACE (City and state or country) Femme Osage, Mo. | | 12. CITIZEN OF WHAT COUNTRY U.S.A. | |
| 13a. FATHER'S NAME William Soendker | | | 13b. MOTHER'S MAIDEN NAME Wilhelmia Remeier | | 14. NAME OF HUSBAND OR WIFE Mary Koelmel | | |
| 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. NO | 17. INFORMANT Mr. Edward W. Soendker | | | Address Wellington, Mo. |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| IMMEDIATE CAUSE (a) Cardiac Decompensation | | | | | | 3 days | |
| DUE TO (b) Myocardial Degeneration | | | | | | 10 Yrs. | |
| DUE TO (c) Arteriosclerosis | | | | | | 20 yrs | |
| 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 3-22-48 to 9-2 59 and last saw him alive on Aug. 29, 1959 Death occurred at 1:45 A m on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | |
| 22a. SIGNATURE <i>Edmund Davidson</i> (Degree or title) DO. | | | 22b. ADDRESS Wellington, Missouri | | | 22c. DATE SIGNED 9-4-59 | |
| 23a. BURIAL CREMATION, REMOVAL (Specify) Burial | 23b. DATE 9/4/1959 | 23c. NAME OF CEMETERY OR CREMATORY St. Lukes Cemetery | | 23d. LOCATION (City, town, or county) Wellington, Mo. | | (State) | |
| 24. FUNERAL DIRECTOR J. Clair Sheppard Wellington, Mo. | | | ADDRESS | 25. DATE RECD. BY LOCAL REG. 9-4-1959 | 26. REGISTRAR'S SIGNATURE <i>Emma Davidson</i> | | |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

MS JUL 6 1959
OCT 13 1959
MS JUN 20 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 J. Blair Shppard

Licensed Embalmer No. 4179
P. O. Address Wellington, N.C.

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.