

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-029706

FILED VS SEP 14 1959

184

Registration District No. _____ Primary Registration District No. 3e38 Registrar's No. 98

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Linn</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Iowa</u> b. COUNTY <u>Decatur</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Brookfield, Mo.</u>		Length of stay in 1b <u>4 Yrs.</u>		c. CITY OR TOWN <u>Leon, Iowa</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>Home Cramer Convalescent</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>Unknown</u>			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Martha</u> Middle <u>Ellen</u> Last <u>Gochenouer</u>				4. DATE OF DEATH Month <u>September</u> Day <u>6</u> Year <u>1959</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</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>2-5-68</u>	9. AGE (last birthday) <u>91</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 <u>Own Home</u>		11. BIRTHPLACE (City and state or country) <u>Fairfield, Iowa</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>Carpenter</u>			13b. MOTHER'S MAIDEN NAME <u>Unknown</u>		14. NAME OF HUSBAND OR WIFE <u>Joseph Gochenouer</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>None</u>	17. INFORMANT Address <u>Mrs Berniece Langlois Linneus, Mo.</u>			
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>Small O. obstruction</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Pneumonia - hypertensive</u>							INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>
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>Sept 1959</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 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>1953</u> to <u>Sept 1959</u> and last saw ^{her} him alive on <u>9-5-59</u> Death occurred at <u>2:55</u> p.m. on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>W.D. Howell M.D.</u>				22b. ADDRESS <u>Brookfield Mo</u>		22c. DATE SIGNED <u>9-8-59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>9-8-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>High Point Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>High Point, Iowa</u>			
24. FUNERAL DIRECTOR <u>Frank Slade</u>		ADDRESS <u>Leon, Iowa</u>	25. DATE RECD. BY LOCAL REG. <u>9-10-59</u>	26. REGISTRAR'S SIGNATURE <u>Katharine Johnson Reg.</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 Frank Alade

Licensed Embalmer No. 4451

P. O. Address Leon Gou

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.