

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS SEP 14 1959

59-029926

Registration District No. 264

Primary Registration District No.

Registrar's No.

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Ozark</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Ozark</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Big Creek</u>		Length of stay in 1b		c. CITY OR TOWN <u>Isabella</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>Hiway 160</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>Resort Area</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>A.</u> Last <u>Hermann</u>				4. DATE OF DEATH Month <u>9</u> - Day <u>5</u> - Year <u>59</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>7-31-1922</u>	9. AGE (last birthday) <u>37</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Resort Owner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Resort</u>		11. BIRTHPLACE (City and state or country) <u>Webster Groves Mo</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>John G. Hermann</u>		13b. MOTHER'S MAIDEN NAME <u>Hattie Morgenstern</u>		14. NAME OF HUSBAND OR WIFE <u>Mary Louise</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>496-29-5157</u>		17. INFORMANT <u>Nadine Hermann, Webster Groves, 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>Broken Neck Skull Fracture</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Fractures of Legs Left Arm</u> DUE TO (c) _____ 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							INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT <input checked="" 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>Car Wreck</u>			
20c. TIME OF INJURY Hour <u>2:15</u> Month, Day, Year <u>9-5-59</u>		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.) <u> Hwy 160</u>		20f. CITY, TOWN, OR LOCATION <u>Big Creek Twp Ozark Mo.</u>	
21. I attended the deceased from _____, to _____ and last saw her/him alive on _____ Death occurred at <u>2:15 P.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>John R. Clary Curran</u> (Degree or title)				22b. ADDRESS <u>Gainesville Mo.</u>		22c. DATE SIGNED <u>9-6-59</u>	
23a. BURIAL CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>9-7-59</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Sunset Burial Park</u>		23d. LOCATION (City, town, or county) (State) <u>Webster Groves, Mo.</u>	
24. FUNERAL DIRECTOR <u>Clint Kingbeard, Gainesville, Mo</u>				25. DATE RECD. BY LOCAL REG. <u>9-12-59</u>		26. REGISTRAR'S SIGNATURE <u>Thana Mahan</u>	

(Licensed Embalmer's Statement on Reverse Side)

INDEXED

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

0061 A K 438

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

John R. Usrey

Licensed Embalmer No. 4885

P. O. Address Gainesville

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.