

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-030170

FILED VS SEP 1 1959

STATE FILE NUMBER

Registration District No. 316 Primary Registration District No. 3060 Registrar's No. 329

1. PLACE OF DEATH a. COUNTY ST. FRANCOIS				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY ST FRANCOIS				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN FARMINGTON		Length of stay in 1b 15 YRS		c. CITY OR TOWN FARMINGTON		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 508 MIDDLE			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 508 MIDDLE		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ETHEL Middle PAULINE Last KROPP			4. DATE OF DEATH Month AUG Day 22 Year 1959					
5. SEX FEMALE	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 AUG. 9, 1914	9. AGE (last birthday) 45 YRS	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) HOUSEWIFE			10b. KIND OF BUSINESS OR INDUSTRY CHAFFEE MISSOURI		11. BIRTHPLACE (City and state or country) U.S.		12. CITIZEN OF WHAT COUNTRY U.S.	
13a. FATHER'S NAME JOHN L. SIMPSON			13b. MOTHER'S MAIDEN NAME EVE MAE LASLEY			14. NAME OF HUSBAND OR WIFE LAWRENCE KROPP		
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. NONE		17. INFORMANT Address MRS. JOHN SIMPSON CHAFFEE, 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) Stiff Man's Syndrome							INTERVAL BETWEEN ONSET AND DEATH 12 YEARS	
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)					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" 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 22 Aug to 22 Aug 59 and last saw her ^{her} _{him} alive on Head when seen Death occurred at 10:40 A m on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) CW Krastain MD				22b. ADDRESS Farmington Mo			22c. DATE SIGNED 8/22/59	
23a. BURIAL, CREMATION, REMOVAL (Specify) Bural		23b. DATE Aug. 25 1959	23c. NAME OF CEMETERY OR CREMATORY Memorial Park		23d. LOCATION (City, town, or county) Cape Girardeau Mo		(State)	
24. FUNERAL DIRECTOR ADDRESS C.H. Cozean Farmington Mo				25. DATE RECD. BY LOCAL REG. Aug 24, 1959		26. REGISTRAR'S SIGNATURE Ether Rudloff		

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 _____

Licensed Embalmer No. 4094

P. O. Address _____

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.