

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-031143

FILED VS AUG 31 1959 224

Registration District No. _____ Primary Registration District No. 3072 Registrar's No. 135

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY Saline				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Saline				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Marshall		Length of stay in 1b 5 Months		c. CITY OR TOWN Slater		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Fitzgibbon Hosp.			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 602 Heilor		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First SOPHIE Middle BROWN Last				4. DATE OF DEATH Month August Day 24 Year 1959				
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 2-21-1875	9. AGE (last birthday) 84	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 Home		11. BIRTHPLACE (City and state or country) Germany		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME Lewis Stoeckel			13b. MOTHER'S MAIDEN NAME Unknown			14. NAME OF HUSBAND OR WIFE Deceased		
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 Wm. H. Brown 1222 S Conway Marshall				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart failure							INTERVAL BETWEEN ONSET AND DEATH ? Unknown	
DUE TO (b) interiorly Heart Disease							Unknown	
DUE TO (c) _____								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Fracture of Femur							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 8 July 1959 to 24 August 1959 and last saw her alive on 24 August 1959 Death occurred at 11:15 P m on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) Robert W. Blask md.				22b. ADDRESS Marshall, Missouri			22c. DATE SIGNED 8-25-1959	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 8-26-1959	23c. NAME OF CEMETERY OR CREMATORY Pleasant Valley Cemetery		23d. LOCATION (City, town, or county) (State) Clotho Minnesota			
24. FUNERAL DIRECTOR Sweeney-Reser Funeral Home Marshall				25. DATE RECD. BY LOCAL REG. 8-25-59		26. REGISTRAR'S SIGNATURE Cecil G. Read		

(Licensed Embalmer's Statement on Reverse Side)

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 Jack W. Reser

Licensed Embalmer No. 464

P. O. Address Marshall

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to do so 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.