

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-031676

FILED VS OCT 6 1959 53

3010

351

STATE FILE NUMBER

DED

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

1. PLACE OF DEATH a. COUNTY <u>Cape Girardeau</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> COUNTY <u>Cape Girardeau</u>									
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Cape Girardeau</u>		Length of stay in 1b <u>35 yrs</u>		c. CITY OR TOWN <u>Cape Girardeau</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>S.E.No.Hospital</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>1626 Luce Street</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <u>Luther</u> Middle <u>Otis</u> Last <u>Eollinger</u>				4. DATE OF DEATH Month <u>September</u> Day <u>27</u> Year <u>1959</u>									
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</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>1/22/1904</u>		9. AGE (last birthday) <u>55</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>Owner & Operator of Crest Cleaners</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Marble Hill, Mo.</u>		11. BIRTHPLACE (City and state or country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY					
13a. FATHER'S NAME <u>J.W.Eollinger</u>				13b. MOTHER'S MAIDEN NAME <u>Minnie Proffer</u>				14. NAME OF HUSBAND OR WIFE <u>Fern Dinsmore Eollinger</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>486-38-1365</u>		17. INFORMANT Address <u>Mrs. Fern Bollinger Cape Gir, 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>Traumatic Embolism of Liver</u>										INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>			
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 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 <u>6-14-55</u> to <u>9-27-59</u> and last saw ^{her} him alive on <u>9-27-59</u> Death occurred at <u>12:45 P.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE <u>W. Peabody, M.D.</u> (Degree or title)						22b. ADDRESS <u>Cape Girardeau, Mo</u>			22c. DATE SIGNED <u>9-28-59</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>9/29/1959</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park</u>		23d. LOCATION (City, town, or county) <u>Cape Girardeau, Mo.</u>		(State)					
24. FUNERAL DIRECTOR <u>I. I. Haman Cape Girardeau, Mo.</u>				25. DATE RECD. BY LOCAL REG. <u>10-3-59</u>		26. REGISTRAR'S SIGNATURE <u>Drena Kasten</u>							

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

MS OCT 7 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 Howard R. Haman

Licensed Embalmer No. 4132

P. O. Address Capri, Florida

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.