

UNL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-035716

FILED VS OCT 19 1959

STATE FILE NUMBER

Registration District No. 115-116 Primary Registration District No. 4187 Registrar's No. 220

INDEXED

1. PLACE OF DEATH a. COUNTY <b>FRANKLIN</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MO.</b> b. COUNTY <b>FRANKLIN</b>					
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>UNION</b>		Length of stay in 1b		c. CITY OR TOWN <b>UNION</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>MCKINLEY &amp; LOCUST ST.</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>MCKINLEY &amp; LOCUST</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>MARGUERITE</b> Middle <b>E.</b> Last <b>SHERMAN</b>				4. DATE OF DEATH Month <b>OCT.</b> Day <b>15,</b> Year <b>1959</b>					
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>AUG. 10, 1864</b>	9. AGE (last birthday) <b>95</b>	IF UNDER 1 YEAR Months <b>2</b> Days <b>5</b>	IF UNDER 24 HR Hours <b></b> Min. <b></b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>HOUSEWIFE</b>		11. BIRTHPLACE (City and state or country) <b>ST. LOUIS, MO.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		
13a. FATHER'S NAME <b>MICHEL MOUTIER</b>			13b. MOTHER'S MAIDEN NAME <b>MARGARET CRIMPLE</b>			14. NAME OF HUSBAND OR WIFE <b>Dec.</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>MARGUERITE BREGLIEB ST. CLAIR, MO</b>				Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. <b>(Trauma)</b> DUE TO (b) <b>(Trauma)</b> DUE TO (c) <b>(Trauma)</b>							INTERVAL BETWEEN ONSET AND DEATH <b>Instant</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>None</b>						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.) <b>None</b>							
20c. TIME OF INJURY Hour <b></b> a.m. <b></b> p.m. <b></b>		Month, Day, Year		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.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from _____ to _____ and last saw her alive on _____. Death occurred at <b>4:00 A</b> m on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <i>[Signature]</i> (Degree or title)				22b. ADDRESS <b>Union Mo.</b>			22c. DATE SIGNED <b>10/16/59</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>OCT. 19, 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>IMMACULATE CONCEPTION UNION</b>		23d. LOCATION (City, town, or county) <b>MO</b>				
24. FUNERAL DIRECTOR <b>OLTMANN FUNERAL HOME</b>				ADDRESS <b>UNION, MO.</b>		25. DATE RECD. BY LOCAL REG. <b>10/16-59</b>		26. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

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 me  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed

*Ralph Ottmann*

Licensed Embalmer No.

*4808*

P. O. Address

*Union, T*

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.