

FURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

Dr. K. Knabb

FILED VS NOV 9 1959

59-035916

STATE FILE NUMBER

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 1190

ENDED

1. PLACE OF DEATH a. COUNTY <u>GREENE</u>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>MISSOURI</u> COUNTY <u>GREENE</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>SPRINGFIELD</u>	Length of stay in 1b <u>64 YRS.</u>	c. CITY OR TOWN <u>SPRINGFIELD</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>BURGE HOSP.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>617 E. MADISON</u>
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print) First Middle Last <u>GUSTAVE C. WIDMEYER</u>			4. DATE OF DEATH Month Day Year <u>NOV. 4 1959</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>9/5/61</u>	9. AGE (last birthday) <u>98</u>	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARMER</u>		11. BIRTHPLACE (City and state or country) <u>AYTON, ONT. CANADA</u>		
12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13a. FATHER'S NAME <u>(unknown) WIDMEYER</u>		13b. MOTHER'S MAIDEN NAME <u>BARBARA SCHLLING</u>		
14. NAME OF HUSBAND OR WIFE <u>MARY WIDMEYER (DEC.)</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>unknown</u>		
17. INFORMANT Address <u>MRS. RALPH FETTER, SPRINGFIELD, 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>Arteriosclerotic heart disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>yes.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Senility & Cachexia.</u>		<u>yes.</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
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input 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 23 Oct. 1959 to 3 Nov. 1959 and last saw her alive on 3 Nov. 1959
 Death occurred at 6:20 A.M. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Samuel E. Smith, M.D.</u>	22b. ADDRESS <u>1630 N. Jefferson</u>	22c. DATE SIGNED <u>6 Nov 59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>11/7/59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MAPLE PARK</u>	23d. LOCATION (City, town, or county) (State) <u>SPRINGFIELD, MO.</u>
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24. FUNERAL DIRECTOR ADDRESS <u>H.H. LOHMEYER SPRINGFIELD, MO.</u>	25. DATE RECD. BY LOCAL REG. <u>11-6-59</u>	26. REGISTRAR'S SIGNATURE <u>Effie S. Melton</u>
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(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 me
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed A. L. McQueen

Licensed Embalmer No. 2727
P. O. Address Springfield, Ill.

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.