URI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS NOV 2 1959

59-036560
STATE FILE NUMBER

AMENDED

Registration District No. 150 Primary Registration District No. 4240 Registrar's No. 239

1. PLACE OF DEATH
a. COUNTY Jackson
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Blue Springs — Length of stay in 1b 75 yrs
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 1605 Main — Inside Limits Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Jackson
c. CITY OR TOWN Blue Springs — Inside Limits Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location) 1605 Main — Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First Jacob Middle P. Last Hertzog
4. DATE OF DEATH: Month Oct Day 20 Year 1959
5. SEX: male
6. COLOR OR RACE: White
7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 12/30/1870
9. AGE (last birthday): 88
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): Retired Farmer
10b. KIND OF BUSINESS OR INDUSTRY: Farm
11. BIRTHPLACE (City and state or country): Lexington Ill.
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13a. FATHER'S NAME: Daniel Hertzog
13b. MOTHER'S MAIDEN NAME: Anna Potts
14. NAME OF HUSBAND OR WIFE: Anna Hertzog
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): None
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Mrs Anna Hertzog — Address: Blue Springs Mo

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac failure — INTERVAL BETWEEN ONSET AND DEATH: 2 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Arterial sclerotic cardio-vascular disease — 10 yrs
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. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
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 10-24-59, to 10-20-59 and last saw him alive on 10-17-59
Death occurred at 1:55 AM on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Merrill R. Bay M.D.
22b. ADDRESS: Blue Springs Mo.
22c. DATE SIGNED: 10/20/59

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: Oct 21 1959
23c. NAME OF CEMETERY OR CREMATORY: Salem Cemetery
23d. LOCATION (City, town, or county) (State): Independence Mo
24. FUNERAL DIRECTOR: Webb Funeral Home — ADDRESS: Blue Springs Mo
25. DATE RECD. BY LOCAL REG.: 10-23-1959
26. REGISTRAR'S SIGNATURE: [illegible]

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT 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 m

~~or by~~ —, Student Embalmer No. —

working under my personal supervision.

Student —
Signature of Student Embalmer

Signed William Frew

Licensed Embalmer No. 4733

P. O. Address Blue Springs

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