

# MURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

# 59-037101

FILED VS NOV 2 1959

STATE FILE NUMBER

Registration District No. 274 Primary Registration District No. 305V Registrar's No. 345

RECEIVED

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Pettis</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Sedalia</u> Length of stay in 1b <u>Life</u> c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Bothwell Hospital</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Pettis</u> c. CITY OR TOWN <u>Sedalia</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>1008 East 10<sup>th</sup> St</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
--	--	--	--

<b>3. NAME OF DECEASED</b> (Type or print) First <u>PAUL</u> Middle <u>GERALD</u> Last <u>BERTHOUEX</u>	<b>4. DATE OF DEATH</b> Month <u>10</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>1-2-1900</u>	9. AGE (last birthday) <u>59</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>Supervisor Car Dept</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Mo. Pac. Shops</u>	11. BIRTHPLACE (City and state or country) <u>Sedalia Mo</u>	12. CITIZEN OF WHAT COUNTRY <u>U S A</u>
--	---	--	--

13a. FATHER'S NAME <u>George P. Berthouex</u>	13b. MOTHER'S MAIDEN NAME <u>Mertie Dunon</u>	14. NAME OF HUSBAND OR WIFE <u>Della Boyle Berthouex</u>
---	---	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>	16. SOCIAL SECURITY NO. <u>702-16-1764</u>	17. INFORMANT <u>Mrs Della Berthouex</u> Address <u>1008 E. 10th</u>
---	--	--

<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cardiac decompensation</u> DUE TO (b) <u>Chronic Myocarditis</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u> <u>3 years</u>
---	---

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 March, 1958 to October 27, 1959 and last saw him alive on 10/27/59  
 Death occurred at 4:25 A m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>W. W. Boyer MD</u> (Degree or title)	22b. ADDRESS <u>Sedalia Mo</u>	22c. DATE SIGNED <u>10/27/59</u>
--	--------------------------------	----------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>10-29-1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Crown Hill</u>	23d. LOCATION (City, town, or county) <u>Sedalia Mo</u>
---	-----------------------------	--	---

24. FUNERAL DIRECTOR <u>McLaughlin Bros</u> ADDRESS <u>Sedalia</u>	25. DATE RECD. BY LOCAL REG. <u>10-28-1959</u>	26. REGISTRAR'S SIGNATURE <u>Frances Shelby</u>
--	--	---

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

8961 7 AOK SA

**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

*K. P. McLeary*

Licensed Embalmer No.

*3153*

P. O. Address

*Sedalia*

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.