

VIRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-037219

FILED VS OCT 16 1959

STATE FILE NUMBER

Registration District No. 294 Primary Registration District No. 30076 Registrar's No. 220

RENDERED

1. PLACE OF DEATH a. COUNTY <u>Randolph</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Moberly</u> Length of stay in 1b <u>45 Yrs.</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Randolph</u> c. CITY OR TOWN <u>Moberly</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>912 Bond St.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>221 S. Morley Str. Wheeler Boarding Home</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>912 Bond St.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>KATHERINE</u> Middle <u>FRANCESCA</u> Last <u>MOHR</u>			4. DATE OF DEATH Month <u>OCT.</u> Day <u>7</u> Year <u>1959</u>		
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> <u>Widowed</u> <input checked="" type="checkbox"/> <u>Divorced</u> <input type="checkbox"/>	8. DATE OF BIRTH <u>9-4-1878</u>	9. AGE (last birthday) <u>81</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HR Hours <u> </u> Min. <u> </u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u> </u>	11. BIRTHPLACE (City and state or country) <u>Prairie Tow, Illinois</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
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13a. FATHER'S NAME <u>Henry Hering</u>	13b. MOTHER'S MAIDEN NAME <u>Frieda Myer</u>	14. NAME OF HUSBAND OR WIFE <u> </u>
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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>None</u>	17. INFORMANT Address <u>Mrs. Ella Personke Steger, Ill.</u>
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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>Heart failure</u> DUE TO (b) <u>Rheumatic valvulitis, mitral unknown</u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	INTERVAL BETWEEN ONSET AND DEATH <u>3 mos.</u>
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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 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.)
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20c. TIME OF INJURY Hour <u> </u> Month, Day, Year <u> </u> a.m. <u> </u> p.m. <u> </u>	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.) <u> </u>	20f. CITY, TOWN, OR LOCATION COUNTY STATE <u> </u>
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21. I attended the deceased from <u>1953</u> to <u>Oct 7 1959</u> and last saw her <u>live on Oct 6, 1959</u> Death occurred at <u>0100</u> A.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Robert Harrison, M.D.</u>	22b. ADDRESS <u>121 S. Wms, Moberly, Mo.</u>	22c. DATE SIGNED <u>10-7-59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>10-10-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Oakland</u>	23d. LOCATION (City, town, or county) (State) <u>Moberly Mo.</u>
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24. FUNERAL DIRECTOR ADDRESS <u>Mahan Funeral Service Moberly</u>	25. DATE RECD. BY LOCAL REG. <u>10-7-59</u>	26. REGISTRAR'S SIGNATURE <u> </u>
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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

John A. Green

Licensed Embalmer No. 3815

P. O. Address Mohale, 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.