

MURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-038726

STATE FILE NUMBER

FILED VS OCT 20 1959 369

Registration District No. **369** Primary Registration District No. **6257** Registrar's No. **8**

MEMORIALIZED

1. PLACE OF DEATH a. COUNTY WAYNE b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN PATTERSON Length of stay in lb 9 1/2 c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ✓ Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MO. b. COUNTY WAYNE c. CITY OR TOWN PATTERSON Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First WILLIAM Middle JOHN Last HOFFMAN				4. DATE OF DEATH Month OCT Day 15 Year 1959									
5. SEX MALE		6. COLOR OR RACE WHITE		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH OCT. 30, 1883		9. AGE (last birthday) 75		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HR Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CONSTRUCTION CONTRACTOR				10b. KIND OF BUSINESS OR INDUSTRY CONSTRUCTION				11. BIRTHPLACE (City and state or country) DAKVILLE MO.		12. CITIZEN OF WHAT COUNTRY U.S.A.			
13a. FATHER'S NAME UNKNOWN				13b. MOTHER'S MAIDEN NAME UNKNOWN				14. NAME OF HUSBAND OR WIFE IDA FLAMM					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO NO				16. SOCIAL SECURITY NO.		17. INFORMANT HATTIE MAY SPARROW Address PATTERSON MO.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) General Cancer Liver and Arteric Poison DUE TO (b) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Arteric Poison 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										INTERVAL BETWEEN ONSET AND DEATH 3 years			
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 1 to 5:30 pm Oct 15-16 and last saw her/him alive on 14 of Oct 1959 Death occurred at his home on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE (Degree or title) J. R. M. J. M. D.						22b. ADDRESS Patterson MO.			22c. DATE SIGNED OCT 15 59				
23a. BURIAL, CREMATION, OR REMOVAL (Specify) REMOVAL		23b. DATE 10-15-1959		23c. NAME OF CEMETERY OR CREMATORY BECK			23d. LOCATION (City, town, or county) (State) BECK, MO.						
24. FUNERAL DIRECTOR GISH FUNERAL HOME ADDRESS PIEDMONT MO.				25. DATE RECD. BY LOCAL REG. 10/15/59		26. REGISTRAR'S SIGNATURE Annie Loulace							

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

VS OCT 28 1950

STATION 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 *Me* Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed *Mawen E Bowler*

Licensed Embalmer No. *4426*

P. O. Address *Piedmont*

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.