

UNIFORM DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-041064

STATE FILE NUMBER

FILED VS DEC 8 1959

Registration District No. 236 Primary Registration District No. 4352 Registrar's No. 69

| | | | | | | | | |
|---|--|---|--|---|--|--|---|-------|
| 1. PLACE OF DEATH a. COUNTY MORGAN | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO b. COUNTY Benton | | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Versailles | | Length of stay in 1b 4 yrs. | | c. CITY OR TOWN EDWARDS | | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Kidwell Rest Home | | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First AMANDA Middle W Last KOSFELD | | | | 4. DATE OF DEATH Month Dec Day 4 Year 1959 | | | | |
| 5. SEX FEMALE | 6. COLOR OR RACE white | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/> | | 8. DATE OF BIRTH Aug 1, 1928 | 9. AGE (last birthday) 31 | IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0 | IF UNDER 24 HR Hours 0 Min. 0 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | | 10b. KIND OF BUSINESS OR INDUSTRY Home | | 11. BIRTHPLACE (City and state or country) MO | | 12. CITIZEN OF WHAT COUNTRY U. S. A | |
| 13a. FATHER'S NAME Louis Mochel | | | 13b. MOTHER'S MAIDEN NAME Mary K Jills | | | 14. NAME OF HUSBAND OR WIFE Divorced | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | | 16. SOCIAL SECURITY NO. none | | 17. INFORMANT Address Tom Mochel - Rt 2 Edwards | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 1 wk. | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ 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 | | | |
| 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 11-28-59 to 12-4-59 and last saw her alive on 12-4-59 Death occurred at 1:45 P m on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | | |
| 22a. SIGNATURE Jack Gunn MD (Deceased's title) | | | | 22b. ADDRESS Versailles, Mo. | | | 22c. DATE SIGNED 12-4-59 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE Dec 6, 1959 | 23c. NAME OF CEMETERY OR CREMATORY CLAYTON CEMETERY | | 23d. LOCATION (City, town, or county) (State) COOPER CO. MO. | | | |
| 24. FUNERAL DIRECTOR John F Reser (Address) Warsaw | | | 25. DATE RECD. BY LOCAL REG. 12-5-59 | | 26. REGISTRAR'S SIGNATURE J L Washburn | | | |

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 Raymond Foster

Licensed Embalmer No. 4626

P. O. Address Versailles

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.