

JURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

'59 0 4 4 9 9 3

FILED VS JAN 11 1960

STATE FILE NUMBER

Registration District No. 276 Primary Registration District No. 5945 Registrar's No. 48

WENDED

| | | | | | | | | | | | | | |
|--|--|---|--|---|---|---|---|--|----------------------------------|---|--|----------------|--|
| 1. PLACE OF DEATH a. COUNTY <u>Phelps</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Franklin</u> | | | | | | | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Rural - N. Dillon</u> | | Length of stay in 1b <u>29rs</u> | | c. CITY OR TOWN <u>Sullivan Mo.</u> | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | | | | | | | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Ferndale Home</u> | | | Inside Limits Yes <input type="checkbox"/> No <input checked="" 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 <u>Cora</u> Middle <u>Kramer</u> Last <u>Kramer</u> | | | | 4. DATE OF DEATH Month <u>Dec.</u> Day <u>23</u> Year <u>1959</u> | | | | | | | | | |
| 5. SEX <u>Female</u> | | 6. COLOR OR RACE <u>White</u> | | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | | 8. DATE OF BIRTH <u>Feb. 26 1873</u> | | 9. AGE (last birthday) <u>86</u> | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HR | |
| 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>none</u> | | 11. BIRTHPLACE (City and state or country) <u>Sullivan Mo.</u> | | 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> | | | | | |
| 13a. FATHER'S NAME <u>Moses Bailey</u> | | | | 13b. MOTHER'S MAIDEN NAME <u>Mary Sheppard</u> | | | | 14. NAME OF HUSBAND OR WIFE <u>Otto Kramer</u> | | | | | |
| 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 <u>L. Jewel English Sullivan Mo.</u> Address | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> | | | | | | | | | | <u>0</u> | | | |
| DUE TO (b) <u>Hypertension</u> | | | | | | | | | | <u>about 6 years</u> | | | |
| 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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input 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 s.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 <u>December 20/59</u> to <u>December 23/59</u> and last saw her <u>alive</u> on <u>November 22, 1959</u> Death occurred at <u>5:30 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | | | | | | | |
| 22a. SIGNATURE <u>C. V. Hammler M.D.</u> (Degree or title) | | | | | | 22b. ADDRESS <u>St. James Ave.</u> | | | 22c. DATE SIGNED <u>12-26-59</u> | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE <u>Dec. 26 1959</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>I.O.O.F.</u> | | 23d. LOCATION (City, town, or county) <u>Sullivan Mo.</u> | | (State) | | | | | |
| 24. FUNERAL DIRECTOR <u>Thomas B Shaffer Sullivan Mo.</u> ADDRESS | | | | 25. DATE RECD. BY LOCAL REG. <u>Dec. 26, 1959</u> | | 26. REGISTRAR'S SIGNATURE <u>Ruth B. Powell</u> | | | | | | | |

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 *Pho. P. Shaffer*

Licensed Embalmer No. 21692

P. O. Address Jullwa

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.