

**COURT DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

'59 0 46 4 8 8

**FILED VS DEC 21 1959**

Registration District No. 224 Primary Registration District No. 3072 Registrar's No. 196

STATE FILE NUMBER

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Saline</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) e. STATE <u>Missouri</u> b. COUNTY <u>Saline</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Marshall</u>		c. CITY OR TOWN <u>Shackelford</u>	
Length of stay in 1b <u>30 Min.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Fitzgibbon Hosp.</u>		d. STREET ADDRESS (If outside, give location) <u>Streets not numbered</u>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <u>LOUISE</u> Middle <u>MARY</u> Last <u>MUENKS</u>			<b>4. DATE OF DEATH</b> Month <u>December</u> Day <u>16</u> Year <u>1959</u>
<b>5. SEX</b> <u>Female</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. Married</b> <input checked="" type="checkbox"/> <b>Never Married</b> <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>8-12-1890</u>
<b>9. AGE</b> (last birthday) <u>69</u>		IF UNDER 1 YEAR Months <u>        </u> Days <u>        </u>	IF UNDER 24 HR Hours <u>        </u> Min. <u>        </u>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Home</u>	<b>11. BIRTHPLACE</b> (City and state or country) <u>Osage County, Mo</u>
<b>12. CITIZEN OF WHAT COUNTRY</b> <u>Usa</u>		<b>13a. FATHER'S NAME</b> <u>John Boessen</u>	
<b>13b. MOTHER'S MAIDEN NAME</b> <u>Unknown</u>		<b>14. NAME OF HUSBAND OR WIFE</b> <u>Jacob Muenks</u>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) Yes <input checked="" type="checkbox"/> No <input checked="" type="checkbox"/> Unknown <input type="checkbox"/>		<b>16. SOCIAL SECURITY NO.</b> X	<b>17. INFORMANT</b> <u>Jacob Muenks Marshall, Mo.</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>Case of Lung.</u> DUE TO (b) <u>Case of Breast.</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>2 weeks</u> <u>3 mo</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
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)	
<b>20c. TIME OF INJURY</b> Hour _____ Month, Day, Year _____ a.m. _____ p.m. _____		<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> <b>NOT WHILE AT WORK</b> <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>20f. CITY, TOWN, OR LOCATION</b> COUNTY STATE	
<b>21. I attended the deceased from</b> <u>fall 59</u> to <u>Dec 16</u> and last saw <u>alive on</u> <u>Dec 15</u> Death occurred at <u>8:00</u> A.m. on the date stated above, and to the best of my knowledge, from the causes stated.			
<b>22a. SIGNATURE</b> (Degree or title) <u>[Signature]</u>		<b>22b. ADDRESS</b> <u>Marshall, Missouri</u>	<b>22c. DATE SIGNED</b> <u>12-16-1959</u>
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>	<b>23b. DATE</b> <u>12-18-1959</u>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Sunset Memorial Cemetery</u>	<b>23d. LOCATION</b> (City, town, or county) (State) <u>Marshall, Mo</u>
<b>24. FUNERAL DIRECTOR</b> ADDRESS <u>Sweeney-Reser Funeral Home Marshall</u>		<b>25. DATE RECD. BY LOCAL REG.</b> <u>12-17-59</u>	<b>26. REGISTRAR'S SIGNATURE</b> <u>[Signature]</u>

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

DEC 29

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed

*Jack W. Reese*

Licensed Embalmer No. 4643

P. O. Address Marshall

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.