

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-000941

FILED VS JAN 11 1960

Registration District No. 115-116 Primary Registration District No. 3020 Registrar's No. 5

STATE FILE NUMBER

INDEXED

1. PLACE OF DEATH a. COUNTY <u>Franklin Co</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St Charles</u>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Washington Mo</u>		Length of stay in 1b <u>1 day</u>		c. CITY OR TOWN <u>Augusta Mo</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>St Francis</u>			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 <u>LYDIA</u> Last <u>FUHR</u>				4. DATE OF DEATH Month <u>Jan.</u> Day <u>2</u> Year <u>1960</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 6-1903</u>		9. AGE (at birthday) <u>56</u> IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> IF UNDER 24 HR: Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>House Work.</u>		11. BIRTHPLACE (City and state or country) <u>New Melle Mo</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		
13a. FATHER'S NAME <u>Herman Thieman</u>			13b. MOTHER'S MAIDEN NAME <u>Anna Madler</u>			14. NAME OF HUSBAND OR WIFE <u>Paul Fuhr</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, per or unknown) (If yes, give war or dates of service) <u>None</u>			16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Baris Fuhr</u> Address <u>Augusta Mo</u>				
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>Amyotrophic Lateral Sclerosis.</u> DUE TO (b) <u> </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		
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 <u> </u> a.m. <u> </u> p.m. <u> </u>		Month, Day, Year							
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.)		20f. CITY, TOWN, OR LOCATION		COUNTY		STATE	
21. I attended the deceased from <u>Dec. 29-59</u> to <u>Jan 2, 60</u> and last saw her <u>alive</u> on <u>Jan 2, 60</u> Death occurred at <u>5:00 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <u>[Signature]</u> (Degree or title)				22b. ADDRESS <u>Washington, Mo.</u>				22c. DATE SIGNED <u>1-4-60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <u>Jan. 5-60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Lutheran Cemetery</u>		23d. LOCATION (City, town, or county) <u>Augusta Mo</u>		(State)	
24. FUNERAL DIRECTOR <u>Olie Shilking</u> ADDRESS <u>Augusta Mo</u>				25. DATE RECD. BY LOCAL REG. <u>1/6/60</u>		26. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

2-7-58
ST

STATEMENT BY LICENSED EMBALMER

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 Howard O Kessler

Licensed Embalmer No. _____

P. O. Address _____

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.