

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-002990

FILED VS JAN 26 1960

Registration District No. 510 Primary Registration District No. 3058 Registrar's No. 15 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>St. Charles</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Montgomery</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Charles</u>		Length of stay in lb <u>29 days</u>	c. CITY OR TOWN <u>Rhineland</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. Joseph Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>Rhineland</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Henry</u> Middle <u>August</u> Last <u>Daller</u>			4. DATE OF DEATH Month <u>Jan.</u> Day <u>18,</u> Year <u>1960</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>July 29, 1879</u>	9. AGE (last birthday) <u>80</u>	IF UNDER 1 YEAR Months <u>5</u> Days <u>29</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Agriculture</u>	11. BIRTHPLACE (City and state or country) <u>Starkenber, Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		
13a. FATHER'S NAME <u>August Daller</u>		13b. MOTHER'S MAIDEN NAME <u>Annie Grotewell</u>		14. NAME OF HUSBAND OR WIFE <u>None</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 Address <u>George Daller, Rhineland, 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>Bronchopneumonia</u> DUE TO (b) <u>Carcinoma of sigmoid</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH <u>1 yr</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		
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 <u>1/18/60</u> to <u>1/19/60</u> and last saw her/him alive on <u>1/18/60</u> Death occurred at <u>4:12 a.m.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE <u>B. Deebie, M.D.</u> (Degree or title)			22b. ADDRESS <u>St. Charles, Mo.</u>		22c. DATE SIGNED <u>1/19/60</u>	
23a. BURIAL, CREMATION, REMOVAL <u>Removal</u>	23b. DATE <u>Jan. 20, 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St Martin Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Starkenber, Mo.</u>			
24. FUNERAL DIRECTOR <u>E. S. Baker Funeral Home, New Florence</u> ADDRESS <u>Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>1/18/60</u>	26. REGISTRAR'S SIGNATURE <u>W. J. Wilson</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
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Frank J. Romano

Licensed Embalmer No. 482

P. O. Address St. Charles

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to do so 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.