

REGISTRATION DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS. FEB 23 1960 38

-60-005115  
STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. 3006 Registrar's No. 95

1. PLACE OF DEATH a. COUNTY <b>Boone</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Johnson</b>											
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>Columbia</b>		Length of stay in 1b <b>1 hour</b>		c. CITY OR TOWN <b>Knob Noster</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>									
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>University Medical Center</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>Green Acres Trailer Court</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>								
3. NAME OF DECEASED (Type or print) First <b>Ruth</b> Middle <b>Mathilde</b> Last <b>Cehrs</b>				4. DATE OF DEATH Month <b>2</b> Day <b>14</b> Year <b>60</b>											
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>9-15-29</b>		9. AGE (last birthday) <b>30</b>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HR Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (City and state or country) <b>Wiesbaden, Germany</b>		12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>					
13a. FATHER'S NAME <b>Herman Burke</b>				13b. MOTHER'S MAIDEN NAME <b>Mathilde</b>				14. NAME OF HUSBAND OR WIFE <b>Earl Cehrs</b>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>-</b>				17. INFORMANT <b>Earl Cehrs - Husband</b>				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute pulmonary edema</b>										INTERVAL BETWEEN ONSET AND DEATH <b>6 days</b>					
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>mitral stenosis, mitral insufficiency, aortic stenosis</b>										<b>5 years</b>					
DUE TO (c) <b>Rheumatic heart disease</b>										<b>15 years</b>					
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 checked="" 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 _____ a.m. _____ p.m. _____				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 <b>7:23 PM 2-14-60</b> to <b>8:15 PM 2-14-60</b> and last saw <input checked="" type="checkbox"/> alive on <b>2-14-60</b> Death occurred at <b>8:15 PM</b> _____ m on the date stated above, and to the best of my knowledge, from the causes stated.															
22a. SIGNATURE (Degree or title) <b>D. M. Martz M.D.</b>						22b. ADDRESS <b>Univ. Hosp., Columbia Mo</b>				22c. DATE SIGNED <b>2-14-60</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>Feb 15 1960</b>		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City, town, or county) (State) <b>Warrensburg Mo</b>							
24. FUNERAL DIRECTOR <b>Brauninger, Warrensburg, Mo</b>				25. DATE RECD. BY LOCAL REG. <b>Feb 16 1960</b>		26. REGISTRAR'S SIGNATURE <b>Mrs R.E. Palmer</b>									

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

SEP 13 1961

**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 *[Handwritten Signature]*

Licensed Embalmer No. 3377

P. O. Address Warensburg

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.