

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

**-60-007022**

**FILED VS. MAR 7 1960**

172

Primary Registration District No. 3034

Registrar's No. 22

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <i>Lafayette</i>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Missouri</i> b. COUNTY <i>Lafayette</i>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>Higginsville</i>		Length of stay in lb <i>2 months</i>		c. CITY OR TOWN <i>Higginsville</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>207 W. 15th St</i>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <i>207 W. 15th St.</i>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <i>Lena</i> Middle <i>Tempel</i> Last <i>Tempel</i>				4. DATE OF DEATH Month <i>Jan.</i> Day <i>27</i> Year <i>1960</i>					
5. SEX <i>Female</i>	6. COLOR OR RACE <i>white</i>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <i>2/3/1875</i>	9. AGE (last birthday) <i>84</i>	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) <i>House Keeping</i>			10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>		11. BIRTHPLACE (City and state or country) <i>Higginsville</i>		12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>		
13a. FATHER'S NAME <i>Ernest Tempel</i>			13b. MOTHER'S MAIDEN NAME <i>Friederickke Roelle</i>			14. NAME OF HUSBAND OR WIFE			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>no</i>			16. SOCIAL SECURITY NO. <i>none</i>		17. INFORMANT <i>Louis H. Tempel - Mayview, Mo.</i>			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) <i>Cerebral Hemorrhage</i>							INTERVAL BETWEEN ONSET AND DEATH <i>1 Mos.</i>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ 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 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 _____ 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 <i>January 7 1960</i> and last saw her <i>January 27-60</i> alive on <i>Jan. 26-1960</i> Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) <i>R. Koppensound. M.D.</i>					22b. ADDRESS <i>Higginsville Mo</i>			22c. DATE SIGNED <i>Jan 29 60</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>Jan. 29, 1960</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Mayview Zion Cemetery</i>		23d. LOCATION (City, town, or county) <i>Mayview Missouri</i>			(State)		
24. FUNERAL DIRECTOR <i>Wieggers-Pickhof-Higginsville, Mo.</i>				25. DATE RECD. BY LOCAL REG. <i>Mar. 3-1960</i>		26. REGISTRAR'S SIGNATURE <i>Lutie Gordon Jordan</i>			

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 Roy F. Wiegman

Licensed Embalmer No. 2883

P. O. Address Higganville

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