

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-007025

FILED VS MAR 2 1960

174

Primary Registration District No. 3035

Registrar's No. 66

STATE FILE NUMBER

INDEXED

1. PLACE OF DEATH a. COUNTY <u>Lafayette</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Lafayette</u>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Lexington</u>		Length of stay in 1b <u>48 hr.</u>		c. CITY OR TOWN <u>Higginsville</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>Memorial Hospital</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>104 E 13th St.</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Walter</u> Middle <u>Henry</u> Last <u>Passe</u>				4. DATE OF DEATH Month <u>February</u> Day <u>3</u> Year <u>1960</u>					
5. SEX <u>male</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>2/10/1888</u>	9. AGE (last birthday) <u>71</u>	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) <u>Farmer + Machinist</u>			10b. KIND OF BUSINESS OR INDUSTRY OWNED OR OPERATED <u>same</u>		11. BIRTHPLACE (City and state or country) <u>Corder, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		
13a. FATHER'S NAME <u>Herman Passe</u>			13b. MOTHER'S MAIDEN NAME <u>Elizabeth Schoppenhorst</u>		14. NAME OF HUSBAND OR WIFE <u>Mrs. Cornelia Passe</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>yes World War I</u>			16. SOCIAL SECURITY NO. <u>500-03-8605</u>		17. INFORMANT <u>Mrs. Cornelia Passe - Higginsville 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>Terminal Broncho pneumonia</u>							INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs.</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Cerebral Vascular Accident</u>							<u>2 wks.</u>		
DUE TO (c) <u>ACU Disease</u>							<u>Years</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>1/19/60</u> to <u>2/3/60</u> and last saw <u>him</u> alive on <u>2/3/60</u> Death occurred at <u>1:55</u> <u>P.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) <u>Adrian B. Best, M.D.</u>				22b. ADDRESS <u>Higginsville Mo.</u>				22c. DATE SIGNED <u>2/11/60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>Feb. 5, 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>City</u>		23d. LOCATION (City, town, or county) (State) <u>Higginsville Missouri</u>				
24. FUNERAL DIRECTOR <u>Wieggers-Pieck Hof.</u>			ADDRESS <u>Higginsville Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>2-24-60</u>		26. REGISTRAR'S SIGNATURE <u>Maura E. Eadler</u>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

MAR 3 1960

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 J. Wiegman

Licensed Embalmer No. 2883

P. O. Address Higginsville

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.