

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-007453

FILED VS MAR 3 1960

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STATE FILE NUMBER

Registration District No. 264 Primary Registration District No. _____ Registrar's No. _____

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|--|--|---|---|
| 1. PLACE OF DEATH a. COUNTY Ozark | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Ozark | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Barren Fork twp. | | Length of stay in lb 52 years | c. CITY OR TOWN Almartha Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION | | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | d. STREET ADDRESS (If outside, give location) Barren fork twp. Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |

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|--|------------------------------|---|---|--|--|
| 3. NAME OF DECEASED (Type or print) Andrew Jackson Eslinger | | | 4. DATE OF DEATH Month 2 Day 26 Year 1960 | | |
| 5. SEX M | 6. COLOR OR RACE W | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 7-7-1875 | 9. AGE (last birthday) 84 | IF UNDER 1 YEAR Months _____ Days _____ |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer | | 10b. KIND OF BUSINESS OR INDUSTRY Own | 11. BIRTHPLACE (City and state or country) Seymour, Mo. | 12. CITIZEN OF WHAT COUNTRY U.S.A. | |
| 13a. FATHER'S NAME A.J. Eslinger | | 13b. MOTHER'S MAIDEN NAME Elizabeth McClue | | 14. NAME OF HUSBAND OR WIFE Callie Cardwell | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT Fred Eslinger Almartha, Mo. Address _____ | |

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| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | | INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) Uremia | | | 1 week |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | DUE TO (b) Urinary retention | | |
| | DUE TO (c) Prostatic hypertrophy | | |
| 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 |

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|---|---|--|---|
| 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 2/27/60 to 2/29/60 and last saw him <input checked="" type="checkbox"/> alive on 2/27/60 Death occurred at 10:15 a m on the date stated above, and to the best of my knowledge, from the causes stated. | | | |

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|---|-------------------------------|--|---|-----------------------------------|
| 22. SIGNATURE (Degree or title) M. J. Hoerman DO | | 22b. ADDRESS Gainesville Mo | | 22c. DATE SIGNED 2-1-60 |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE 2-29-1960 | 23c. NAME OF CEMETERY OR CREMATORY Jackson | 23d. LOCATION (City, town, or county) (State) Ozark Co. Mo. | |
| 24. FUNERAL DIRECTOR Clinkingbeard Gainesville, Mo. | | 25. DATE RECD. BY LOCAL REG. 3-1-60 | 26. REGISTRAR'S SIGNATURE Theresa Matan | |

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 John R. Urey
Licensed Embalmer No. 4883
P. O. Address Lainville

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.