

DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS FEB 23 1960 273

-60-007501
STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. 3051 Registrar's No. 25

1. PLACE OF DEATH a. COUNTY <u>PERRY</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>PERRYVILLE</u> Length of stay in 1b <u>1 WEEK</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>PERRY CO MEMORIAL</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO.</u> b. COUNTY <u>STE. GENEVIEVE</u> c. CITY OR TOWN <u>STE. GENEVIEVE</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>245 MERCHANT ST</u> Residence on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>LAWRENCE WILLIAM DONZE</u>			4. DATE OF DEATH Month Day Year <u>FEB 7 1960</u>				
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</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>11/8/83</u>	9. AGE (last birthday) <u>76</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>RETIRED FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>WEINBARTEN MO</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>MEINRA DONZE</u>			13b. MOTHER'S MAIDEN NAME <u>WHILONA YOLLERST</u>		14. NAME OF HUSBAND OR WIFE <u>ELIZABETH HUER</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>499.38-0935</u>		17. INFORMANT Address <u>Edna Donze da Stenamen Dr</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>Posterior myocardial infarction</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 wk.</u>	
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"/> N. <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>2-1-60</u> to <u>3-7-60</u> and last saw ^{her} him alive on <u>2-7-60</u> Death occurred at <u>12:40</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>J. C. Fairchild, MD</u>				22b. ADDRESS <u>Perryville, Mo.</u>		22c. DATE SIGNED <u>2-9-60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <u>2/10/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>VALLE SPRING</u>		23d. LOCATION (City, town, or county) (State) <u>STE. GENEVIEVE MO</u>	
24. FUNERAL DIRECTOR ADDRESS <u>Doc. Roche Ste. Stenamen Dr</u>				25. DATE RECD. BY LOCAL REG. <u>2-11-60</u>		26. REGISTRAR'S SIGNATURE <u>Joe J. Gallner</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 Adrian J. Ellis

Licensed Embalmer No. 4740

P. O. Address Ste Genevieve

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.