

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS FEB 25 1960

-60-007788

Registration District No. 310 Primary Registration District No. 3058 Registrar's No. 43 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>St Charles</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>St. Charles</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St Charles</u>		Length of stay in 1b <u>4 yrs.</u>	c. CITY OR TOWN <u>Defiance</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Hill Side Nursing Home</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>R.R. 1</u>
		Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Hanna</u> Middle <u>Yogt</u> Last <u>Yogt</u>			4. DATE OF DEATH Month <u>Feb.</u> Day <u>13</u> Year <u>1960</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 8, 1873</u>	9. AGE (last birthday) <u>86</u>	IF UNDER 1 YEAR Months <u>3</u> Days <u>5</u> Hours <u></u> Min. <u></u>	IF UNDER 24 HR Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home Duties</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home Duties</u>	11. BIRTHPLACE (City and state or country) <u>Defiance, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Porter</u>		13b. MOTHER'S MAIDEN NAME <u>Unknown</u>		14. NAME OF HUSBAND OR WIFE <u>George Frank Yogt</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>None</u>	17. INFORMANT <u>Loy Yogt, Defiance R.R. 1, Mo.</u>			

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)	<u>Pneumonia, Bronchop</u>	<u>2 day</u>
DUE TO (b)	<u>Fracture Right femur,</u>	<u>4 wk</u>
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 checked="" 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.) <u>Fell at home</u>			
20c. TIME OF INJURY Hour <u></u> Month, Day, Year <u></u> a.m. <u></u> p.m. <u></u>	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.) <u>092</u>	20f. CITY, TOWN, OR LOCATION <u>Defiance</u>	COUNTY <u>Mo.</u>	STATE <u>Mo.</u>
21. I attended the deceased from <u>1:30</u> to <u>1960</u> and last saw her alive on <u>Feb 12, 1960</u> Death occurred at <u>1:30</u> m on the date stated above, and to the best of my knowledge, from the causes stated.					

22a. SIGNATURE <u>W.H. Poppemeier MD</u> (Degree or title)		22b. ADDRESS <u>St Charles, Mo</u>		22c. DATE SIGNED <u>Feb 15 1960</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>2/16/1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St Paul Evr. Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Defiance Mo.</u>		
24. FUNERAL DIRECTOR <u>T.J. Pitman</u>		ADDRESS <u>Wentzville, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>2/15/60</u>	26. REGISTRAR'S SIGNATURE <u>Marcella Wilson</u>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Reston Passmore

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed

Carlton J. Pitman

Licensed Embalmer No. 4974

P. O. Address Wentzville

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.