

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-009728

FILED VS. ABE 1 1 1960

Primary Registration District No. 3000 Registrar's No. 95

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>Adair</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>Adair</b>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kirksville</b>		Length of stay in lb <b>10 days</b>		c. CITY OR TOWN <b>Novinger</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Laughlin Hosp.</b>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>Route # 3</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JOE</b> Middle <b>POSHEK</b> Last				4. DATE OF DEATH Month <b>April</b> Day <b>2</b> Year <b>1960</b>				
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> <del>XXXXXXXXXX</del> <del>XXXXXXXXXX</del>	8. DATE OF BIRTH <b>4/29/89</b>	9. AGE (last birthday) <b>70</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days	IF UNDER 24 HR Hours	IF UNDER 24 HR Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Miner &amp; Carpenter, Retired, construction, Lingo, Macon, Mo.</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>U S</b>		12. CITIZEN OF WHAT COUNTRY	
13a. FATHER'S NAME <b>John Poshek</b>			13b. MOTHER'S MAIDEN NAME <b>Josephine Povlovich</b>			14. NAME OF HUSBAND OR WIFE <b>Willa Poshek</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>494-05-5391</b>		17. INFORMANT <b>Willa Poshek, Novinger, Mo.</b>			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) <b>Circulatory collapse</b> DUE TO (b) <b>Post-surgical uremia &amp; shock</b> DUE TO (c) <b>Vesicle calculi and cystitis</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.								INTERVAL BETWEEN ONSET AND DEATH <b>30 min</b> <b>4 days</b> <b>unknown</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Arteriosclerosis &amp; coronary insufficiency</b>						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 <b>Mar. 24, 1960</b> , to <b>April 2, 1960</b> and last saw him alive on <b>April 2, 1960</b> Death occurred at <b>12:45 P.M.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <b>Jack A. Auster D.D.</b>				22b. ADDRESS <b>Kirksville Mo.</b>		22c. DATE SIGNED <b>4/4/60</b>		
23a. BURIAL (Specify) <b>Burial</b>		23b. DATE <b>4/5/60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Novinger</b>		23d. LOCATION (City, town, or county) <b>Novinger, Adair, Mo.</b>		(State)	
24. FUNERAL DIRECTOR <b>Doris W. Foster</b> <b>Foster Memorial Home, Kirksville, Mo.</b>			25. DATE RECD. BY LOCAL REG. <b>4-5-1960</b>		24. REGISTRAR'S SIGNATURE <b>Doris W. Rattliff</b>			

DOCUMENT

MEDICAL CERTIFICATION  
**Auster**

BY AFFIDAVIT OF

JACK A. AUSTERLIDG

APP

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 *Nova E. Foster*  
Nova E. Foster

Licensed Embalmer No. 4742  
P. O. Address Kirksville, Mo.

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.