

**JURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**60-009895**

**FILED VS APR 11 1960**

38

Primary Registration District No. 3006

Registrar's No. 207

STATE FILE NUMBER

20(f) near Sweetsprings, Saline Co. near Sedalia  
 DOCUMENT  
 BY AFFIDAVIT OF attending physician  
 MEDICAL CERTIFICATION

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Boone</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Columbia</u> Length of stay in 1b <u>6 days</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>University of Mo. Med. Center</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Saline</u> c. CITY OR TOWN <u>Sweet Springs</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>311 Locust St.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Herbert</u> Middle <u>Joseph</u> Last <u>Lotz</u>			<b>4. DATE OF DEATH</b> Month <u>April</u> Day <u>3</u> Year <u>1960</u>				
<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. Married</b> <input checked="" type="checkbox"/> <b>Never Married</b> <input type="checkbox"/> <b>Widowed</b> <input type="checkbox"/> <b>Divorced</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>10-21-96</u>	<b>9. AGE</b> (last birthday) <u>63</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>City Clerk</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>City Government</u>		<b>11. BIRTHPLACE</b> (City and state or country) <u>Cola Camp Mo</u>		<b>12. CITIZEN OF WHAT COUNTRY</b> <u>United States</u>	
<b>13a. FATHER'S NAME</b> <u>William Lotz</u>		<b>13b. MOTHER'S MAIDEN NAME</b> <u>Mary Harms</u>		<b>14. NAME OF HUSBAND OR WIFE</b> <u>Mary Lotz</u>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <u>489-16-7327</u>		<b>17. INFORMANT</b> <u>Hospital Record University of Mo. Med Center</u> Address <u>Columbia, Mo.</u>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Anoxia</u> DUE TO (b) <u>Crushed Chest - with flail segment</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							
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			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	<b>20a. ACCIDENT</b> <input checked="" type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.) <u>While driving his car, rear-end collision with tractor-trailer</u>					
<b>20c. TIME OF INJURY</b> Hour <u>5:15</u> Month, Day, Year <u>3-27-60</u>	<b>20d. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Highway</u>						
<b>20e. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	<b>20f. CITY, TOWN, OR LOCATION</b> <u>Near Sweet Springs</u>		<b>20g. COUNTY</b> <u>Saline</u>		<b>20h. STATE</b> <u>Mo.</u>		
<b>21. I attended the deceased from</b> <u>3-27-60</u> to <u>4-3-60</u> and last saw her/him alive on <u>4-2-60</u> Death occurred at <u>12:15</u> A.M. on the date stated above, and to the best of my knowledge, from the causes stated.							
<b>22a. SIGNATURE</b> (Degree or title) <u>Earl J. Wigger, Jr. M.D.</u>			<b>22b. ADDRESS</b> <u>U. of Mo. Medical Center</u>		<b>22c. DATE SIGNED</b> <u>4/3/60</u>		
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>REMOVAL</u>		<b>23b. DATE</b> <u>4-3-60</u>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Fairview Cerm</u>		<b>23d. LOCATION</b> (City, town, or county) (State) <u>Sweet Springs Mo</u>		
<b>FUNERAL DIRECTOR</b> <u>Parker Funeral Service</u> ADDRESS <u>Columbia</u>			<b>25. DATE RECD. BY LOCAL REG.</b> <u>April 3 1960</u>	<b>26. REGISTRAR'S SIGNATURE</b> <u>Mrs. R.E. Palmer</u>			

VS APR 26 1960

APR 1

**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 George C. Kerb

Licensed Embalmer No. 4752

P. O. Address Columbia

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.