

# STATE DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-013783

FEB 23 1960

Registration District No. 319 Primary Registration District No. 4469 Registrar's No. 11 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>STE. GENEVIEVE</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>STE. GENEVIEVE</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>STE. GENEVIEVE</u>		Length of stay in 1b <u>LIFE</u>		c. CITY OR TOWN <u>STE. GENEVIEVE</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>STE. GENEVIEVE REST HOME</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>NO MAIN ST</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ALICE</u> Middle <u>MARY</u> Last <u>KOHN</u>				4. DATE OF DEATH Month <u>FEB</u> Day <u>14</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>12/28/81</u>	9. AGE (last birthday) <u>88</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>AT HOME</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>STE. GENEVIEVE MO</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>FERDINAND MOSER</u>			13b. MOTHER'S MAIDEN NAME <u>MARGARET GARRET</u>			14. NAME OF HUSBAND OR WIFE <u>CHARLES KOHN</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.		17. INFORMANT <u>Mrs. Owen Samson Co. Sturgeon Mo</u> 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) <u>Arteriosclerosis</u> DUE TO (b) <u>Chronic myocarditis</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <u>?</u>	
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>Dec. 16 - 1959</u> to <u>Feb. 15, 1960</u> and last saw her alive on <u>Feb. 14, 1960</u> Death occurred at <u>3:30 a.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <u>R. L. Lanning M.D.</u> (Degree or title)				22b. ADDRESS <u>St. Genevieve Mo</u>			22c. DATE SIGNED <u>2/16/60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE <u>2/17/60</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 <u>Geo. C. Bochs St. Genevieve Mo</u> ADDRESS _____			25. DATE RECD. BY LOCAL REG. <u>Feb 16, 1960</u>		26. REGISTRAR'S SIGNATURE <u>Quill Barber</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 St. Geneva

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.