

# RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS MAY 10 1960

53

Registration District No. \_\_\_\_\_ Primary Registration District No. 3010

Registrar's No. 184

=60-014460  
STATE FILE NUMBER

INDEXED

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Cape Girardeau</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Cape Girardeau</u> Length of stay in 1b <u>1 hour</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Southeast Hospital</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>Cape Girardeau</u> c. CITY OR TOWN <u>Jackson</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>West Main</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>				
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Otto</u> Middle <u>J.</u> Last <u>Herb</u>			<b>4. DATE OF DEATH</b> Month <u>April</u> Day <u>27</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 type="checkbox"/> <b>Never Married</b> <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>3/9/1886</u>	<b>9. AGE</b> (last birthday) <u>74</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>Tool and die maker</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Self employed</u>		<b>11. BIRTHPLACE</b> (City and state or country) <u>Fremont, Mich.</u>		<b>12. CITIZEN OF WHAT COUNTRY</b> <u>U. S. A.</u>		
<b>13a. FATHER'S NAME</b> <u>John G. Herb</u>			<b>13b. MOTHER'S MAIDEN NAME</b> <u>unknown</u>			<b>14. NAME OF HUSBAND OR WIFE</b> <u>none</u>		
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>			<b>16. SOCIAL SECURITY NO.</b> <input checked="" type="checkbox"/>		<b>17. INFORMANT</b> <u>Andrew Perrin</u> Address <u>Jackson, 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>Acute Coronary Thrombosis</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <u>2 hr</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"/> 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 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.)				
<b>20c. TIME OF INJURY</b> Hour _____ a.m. _____ p.m. Month, Day, Year _____		<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> <b>NOT WHILE AT WORK</b> <input type="checkbox"/>						
<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>20f. CITY, TOWN, OR LOCATION</b>		<b>COUNTY</b>		<b>STATE</b>		
<b>21. I attended the deceased from</b> <u>4-27-60</u> to <u>4-27-60</u> and last saw <sup>her</sup> him alive on <u>4-27-60</u> Death occurred at <u>Jackson, Mo., 12:15 P.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.								
<b>22a. SIGNATURE</b> (Degree or title) <u>E. J. McDonald, M.D.</u>				<b>22b. ADDRESS</b> <u>Jackson, Mo.</u>			<b>22c. DATE SIGNED</b> <u>4-29-60</u>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>23b. DATE</b> <u>May 2, 1960</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Wayville</u>		<b>23d. LOCATION</b> (City, town, or county) (State) <u>Wayville Mich.</u>		
<b>24. FUNERAL DIRECTOR</b> <u>J. C. Crawford</u> Address <u>Jackson, Mo.</u>				<b>25. DATE RECD. BY LOCAL REG.</b> <u>5-2-1960</u>		<b>26. REGISTRAR'S SIGNATURE</b> <u>Gene Kasten</u>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

JUN 1 1960

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 Lynman Steele

Licensed Embalmer No. 2476

P. O. Address Jackson

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.