

# DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

LED VS APR 18 1960

-60-014744

STATE FILE NUMBER

Registration District No. 115-116 Primary Registration District No. 3020 Registrar's No. 84

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Franklin</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Washington</u> Length of stay in 1b <u>37</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Francis Hosp.</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>Mo.</u> b. COUNTY <u>Franklin</u> c. CITY OR TOWN <u>Washington</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>R. # 2</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Adele</u> Middle <u>B.</u> Last <u>LOTTMANN</u>			<b>4. DATE OF DEATH</b> Month <u>April</u> Day <u>15</u> Year <u>1960</u>				
<b>5. SEX</b> <u>female</u>	<b>6. COLOR OR RACE</b> <u>white</u>	<b>7. Married</b> <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>July 29, 1922</u>	<b>9. AGE (last birthday)</b> <u>37</u>	IF UNDER 1 YEAR Months <u>8</u> Days <u>16</u>	IF UNDER 24 HR Hours <u>16</u> Min. <u></u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, then if retired) <u>Home Maker</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Own Home</u>		<b>11. BIRTHPLACE</b> (City and state or country) <u>Washington, Mo.</u>		<b>12. CITIZEN OF WHAT COUNTRY</b> <u>U.S.A.</u>	
<b>13a. FATHER'S NAME</b> <u>Oscar J. Wellenkamp</u>		<b>13b. MOTHER'S MAIDEN NAME</b> <u>Florence Koehring</u>		<b>14. NAME OF HUSBAND OR WIFE</b> <u>Vernon G. Lottmann</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> <u>499-12-6033</u>		<b>17. INFORMANT</b> <u>Vernon G. Lottmann, Washington, Mo.</u> Address			
<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>Septic Carcinoma Toxic</u> DUE TO (b) <u>Carcinoma of Uterus (uterus)</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>6 mos</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 type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/>	<b>20b. SUICIDE</b> <input type="checkbox"/>	<b>20c. HOMICIDE</b> <input type="checkbox"/>	<b>20d. 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"/> NOT WHILE AT WORK <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>		COUNTY _____ STATE _____			
<b>21. I attended the deceased from</b> <u>Jan 7, 1960</u> to <u>April 19, 1960</u> and last saw her alive on <u>April 19, 1960</u> Depth occurred at <u>12:20 a.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>[Signature] M.D.</u>			<b>22b. ADDRESS</b> <u>205 Eber Washington, Mo.</u>		<b>22c. DATE SIGNED</b> <u>4/15/60</u> (State)		
<b>23a. BURIAL, CREMATION, OR REMOVAL (Specify)</b> <u>Burial</u>		<b>23b. DATE</b> <u>April 18, 1960</u>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>St. Gertrudes Cem. Krakow, Mo.</u>		<b>23d. LOCATION</b> (City, town, or county)		
<b>24. FUNERAL DIRECTOR</b> <u>Meberg-Vitt Inc. Washington, Mo.</u> ADDRESS		<b>25. DATE REGD. BY LOCAL REG.</b> <u>4/14/60</u>		<b>26. REGISTRAR'S SIGNATURE</b> <u>[Signature]</u>			

DOCUMENT BY MEDICAL CERTIFICATION AFFIDAVIT OF

APR 21 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  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_

Signed Vernon C. Vedder

Signature of Student Embalmer

Licensed Embalmer No. 5031

P. O. Address Washington

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.