

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-014755

LED VS MAY 2 1960

Registration District No. 115-116 Primary Registration District No. 3020 Registrar's No. 94

STATE FILE NUMBER

| | | | | | | | |
|--|---|---|--------------------------------------|--|--|---|---------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Franklin | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri COUNTY Franklin | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Washington | | Length of stay in 1b 6 years | | c. CITY OR TOWN Washington | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 618 Market St. | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) 618 Market St. | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First ANDREW Middle GEORGE Last VOSS | | | | 4. DATE OF DEATH Month April Day 27 Year 1960 | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 4/23/1883 | 9. AGE (last birthday) 77 | IF UNDER 1 YEAR Months 0 Days 4 | | IF UNDER 24 HR Hours 4 Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming | | 10b. KIND OF BUSINESS OR INDUSTRY Own Farm | | 11. BIRTHPLACE (City and state or country) Neier, Missouri | | 12. CITIZEN OF WHAT COUNTRY U.S.A. | |
| 13a. FATHER'S NAME William Voss | | 13b. MOTHER'S MAIDEN NAME Katherine Extein | | 14. NAME OF HUSBAND OR WIFE Mathilda (nee Mueller) | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 487-20-8626 | | 17. INFORMANT Mathilda Voss, Washington, Mo. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO (b) Atherosclerotic Heart Disease DUE TO (c) Cerebral Hemorrhage - 1958 Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | | | | | INTERVAL BETWEEN ONSET AND DEATH 10 min 10 year | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Cerebral Hemorrhage - 1958 | | | | 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 10:30 a.m. 1958 Month, Day, Year April, 1960 | 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 10:30 a.m. CST on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | |
| 22a. SIGNATURE John Bryan MD. (Degree or title) | | | | 22b. ADDRESS Washington, Mo. | | 22c. DATE SIGNED 4-27-60 | |
| 23a. BURIAL CREMATION, REMOVAL (Specify) Burial | 23b. DATE Apr. 30, 1960 | 23c. NAME OF CEMETERY OR CREMATORY Resurrection Cemetery | | 23d. LOCATION (City, town, or county) (State) St. Louis, Cy. Mo. | | | |
| 24. FUNERAL DIRECTOR Henry W. Otto, Washington, Mo. | | 25. DATE REGD. BY LOCAL REG. 4/28/60 | | 26. REGISTRAR'S SIGNATURE John Bryan MD. | | | |

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

MAY 3 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 _____
Signature of Student Embalmer

Signed

Henry W. Otto

Licensed Embalmer No. 3560

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.