

UNITED STATES DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS JUN 6 1960 53

=60-018597

Registration District No. Primary Registration District No. 3010 Registrar's No. 210 STATE FILE NUMBER

ENDED

1. PLACE OF DEATH a. COUNTY <u>CAPO</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>WAYNE</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>CAPO GIRARDEAU</u>		c. CITY OR TOWN <u>CAPO GIRARDEAU</u>	
c. FULL NAME OF (If NOT in hospital, give location) <u>ST FRANCIS</u>		d. STREET ADDRESS (If outside, give location) <u>Y6 No</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>JOSEPH. POPE ALXANDER</u>		4. DATE OF DEATH Month Day Year <u>5-14-1960</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐	8. DATE OF BIRTH <u>4-21-1882</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>FARMER</u>	
11. BIRTHPLACE (City and state or country) <u>CASCAIDA MO</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>JAMES ALXANDER</u>		13b. MOTHER'S MAIDEN NAME <u>EVA C MYERS</u>	
14. NAME OF HUSBAND OR WIFE <u>ALICE ALXANDER</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT <u>MILK ALXANDER CASCAIDA MO</u>	
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>acute myocardial infarction</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>arteriosclerosis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒			20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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. Month, Day, Year p.m.
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒		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>5-11-60</u> to <u>5-14-60</u> and last saw her <u>alive</u> on <u>5-14-60</u> Death occurred at <u>10:30 PM</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Charles E. Teltow MD</u>		22b. ADDRESS <u>714 Broadway, Cape Girardeau, Mo.</u>	
22c. DATE SIGNED <u>5/17/60</u>		22d. LOCATION (City, town, or county) (State) <u>GRAVADION MO</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>5/17-60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>LUTHERAN CEM</u>		23d. LOCATION (City, town, or county) (State) <u>GRAVADION MO</u>	
24. FUNERAL DIRECTOR <u>Edman Margman</u>		25. DATE RECD. BY LOCAL REG. <u>5-31-1960</u>	
26. REGISTRAR'S SIGNATURE <u>Gene Katers</u>			

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

OK

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

Raymond B. Wilson

Licensed Embalmer No. *4884*

P. O. Address *Fredricksburg*

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.