

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-020256

FILED VS MAY 23 1960 261

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 120

STATE FILE NUMBER

| | | | | | | | |
|---|--|---|--|--|--|--|---|
| 1. PLACE OF DEATH a. COUNTY Nodaway | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY Nodaway | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Conception | | Length of stay in lb 28 yrs. | | c. CITY OR TOWN Conception | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Conception Abbey | | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) Conception Abbey | | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First Brother NICHOLAS Middle ANTHONY Last ANTERMEYER | | | | 4. DATE OF DEATH Month May Day 8 Year 1960 | | | |
| 5. SEX Male | 6. COLOR OR RACE Wht | 7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | | 8. DATE OF BIRTH 4-28-1891 | 9. AGE (last birthday) 69 | 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) Religious | | 10b. KIND OF BUSINESS OR INDUSTRY Religious | | 11. BIRTHPLACE (City and state or country) St. Joseph, Mo. | | 12. CITIZEN OF WHAT COUNTRY USA | |
| 13a. FATHER'S NAME Joseph Antermeyer | | | 13b. MOTHER'S MAIDEN NAME Mary Wisel | | 14. NAME OF HUSBAND OR WIFE -- | | |
| 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. none | | 17. INFORMANT Conception Abbey, Conception, 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) Cerebrovascular thrombosis DUE TO (b) Cerebral arteriosclerosis DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.) | | | | | | INTERVAL BETWEEN ONSET AND DEATH Just > 5 yrs | |
| 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 | |
| 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 checked="" 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 Jan 14, 1960 to May 8, 1960 and last saw her April 18, 1960 live on Death occurred at 8:20 p.m. on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | |
| 22a. SIGNATURE Conception M.D. (Degree or title) | | | | 22b. ADDRESS Marionville, Mo. | | | 22c. DATE SIGNED 5-7-60 |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE May 11, 1960 | 23c. NAME OF CEMETERY OR CREMATORY St. Columba Cemetery | | 23d. LOCATION (City, town, or county) Conception, Mo. | | | (State) |
| 24. FUNERAL DIRECTOR JOHNSON FUNERAL HOMES, Conception Jct., Mo. ADDRESS | | | | 25. DATE RECD. BY LOCAL REG. 5-16 60 | | 26. REGISTRAR'S SIGNATURE Theresa Hult | |

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 m

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed

Loss E. Johnson

Licensed Embalmer No. 4948

P. O. Address Stanberry

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comp
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.