

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS MAY 16 1960

-60-020341

STATE FILE NUMBER

Registration District No. 274 Primary Registration District No. 3052 Registrar's No. 178

1. PLACE OF DEATH a. COUNTY <u>Pettis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Benton</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Sedalia</u>		Length of stay in 1b <u>6 Days</u>	c. CITY OR TOWN <u>Cole Camp</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Bothwell Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>-----</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Lucy</u> Middle <u>Melvina</u> Last <u>Lutjen</u>			4. DATE OF DEATH Month <u>May</u> Day <u>6th</u> Year <u>1960</u>		
--	--	--	--	--	--

5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>10-19-85</u>	9. AGE (last birthday) <u>74</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HR Hours <u> </u> Min. <u> </u>
-------------------------	----------------------------------	---	-------------------------------------	-------------------------------------	--	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wrie</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (City and state or country) <u>Durock Mo</u>	12. CITIZEN OF WHAT COUNTRY <u>U S A</u>
--	--	--	---

13a. FATHER'S NAME <u>Claus Schumaker</u>	13b. MOTHER'S MAIDEN NAME <u>Ara Rogers</u>	14. NAME OF HUSBAND OR WIFE <u>Harry B Lutjen</u>
--	--	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT <u>m Harry C Lutjen</u>	Address <u>Sedalia Mo</u>
--	--	--	------------------------------

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u>		<u>immediate</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Coronary Thrombosis</u>	<u>3 days</u>
	DUE TO (c) <u>Arteriosclerosis</u>	<u>5 years</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

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 <u> </u> Month, Day, Year <u> </u>	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 <u>6-24-57</u> to <u>4-29-60</u> and last saw her alive on <u>5-4-60</u> Death occurred at <u>4:00</u> <u>A.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>[Signature]</u> (Degree or title)	22b. ADDRESS <u>Cole Camp, Mo</u>	22c. DATE SIGNED <u>5-11-60</u>
--	--------------------------------------	------------------------------------

23a. BURIAL, CREMATION, REMOVAL, (Specify) <u>Burial</u>	23b. DATE <u>5-13-1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cole Camp Memorial</u>	23d. LOCATION (City, town, or county) <u>Cole Camp Mo</u>	(State)
---	-------------------------------	---	--	---------

24. FUNERAL DIRECTOR <u>E L Eickhoff</u>	ADDRESS <u>Cole Camp Mo</u>	25. DATE RECD. BY LOCAL REG. <u>May 13 1960</u>	26. REGISTRAR'S SIGNATURE <u>[Signature]</u>
---	--------------------------------	--	---

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
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed E L Eickhoff
E L Eickhoff

Licensed Embalmer No. 730

P. O. Address Cole Camp Mo

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