

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS AUG 3 1960

-60-026432

STATE FILE NUMBER

Registration District No. 119 Primary Registration District No. 4192 Registrar's No. 18

1. PLACE OF DEATH a. COUNTY <u>Gasconade</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Gasconade</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Morrison</u>		Length of stay in 1b <u>60 Yrs.</u>	c. CITY OR TOWN <u>Morrison</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>Morrison, Mo.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>EDWARD</u> Middle <u>HENRY</u> Last <u>AUGUSTINE</u>			4. DATE OF DEATH Month <u>July</u> Day <u>22</u> Year <u>1960</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Cau.</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>6-28-1878</u>	9. AGE (last birthday) <u>82</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>Iron Worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Gov't Boat Yards</u>	11. BIRTHPLACE (City and state or country) <u>Little Berger, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>Louis Augustine</u>		13b. MOTHER'S MAIDEN NAME <u>Unknown</u>		14. NAME OF HUSBAND OR WIFE <u>Frances Gerritsen Augustine</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u> </u>		16. SOCIAL SECURITY NO. <u> </u>	17. INFORMANT Address <u>Mrs. Frances Augustine-Morrison 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>Arteriosclerotic heart disease</u>					INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Nephrolithiasis</u>				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> a.m. / p.m. Month, Day, Year <u> </u>						
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 <u>3-2-58</u> to <u>7-22-60</u> and last saw ^{her} him alive on <u>7-21-60</u> Death occurred at <u>4 AM</u> on the date stated above, and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE (Degree or title) <u>Cavel T. Shaw, M.D.</u>			22b. ADDRESS <u>Hermann, Mo.</u>		22c. DATE SIGNED <u>7-22-60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>7-25-1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Assumption Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Morrison, Missouri</u>			
24. FUNERAL DIRECTOR <u>Hugo H. Blumer</u>		ADDRESS <u>Hermann, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>7-23-60</u>	26. REGISTRAR'S SIGNATURE <u>Delma Uffelmann</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 Roger W. Blument

Licensed Embalmer No. 5055

P. O. Address Hermann

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.