URI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

-60-030151

STATE FILE NUMBER

FILED VS AUG 29 1960

Registration District No. 115-116 Primary Registration District No. 3020 Registrar's No. 201

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DOCUMENT

BY AFFIDAVIT OF

MEDICAL CERTIFICATION

1. PLACE OF DEATH
a. COUNTY Franklin.
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Washington. Length of stay in 1b 73 yrs.
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Francis Hospital. Inside Limits Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri. b. COUNTY Franklin.
c. CITY OR TOWN Washington. Inside Limits Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location) 208 E. Main St. Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print) First Minnie Middle Last Hesse.

4. DATE OF DEATH Month August Day 23, Year 1960.

5. SEX Female

6. COLOR OR RACE White.

7. Married ☐ Never Married ☒ Widowed ☐ Divorced ☐

8. DATE OF BIRTH 5/18/1887

9. AGE (last birthday) 73 IF UNDER 1 YEAR Months 3 Days 5 IF UNDER 24 HR Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework.

10b. KIND OF BUSINESS OR INDUSTRY x

11. BIRTHPLACE (City and state or country) Washington, Mo.

12. CITIZEN OF WHAT COUNTRY U. S. A.

13a. FATHER'S NAME August Hesse.

13b. MOTHER'S MAIDEN NAME Minnie Toenne.

14. NAME OF HUSBAND OR WIFE none.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No. (If yes, give war or dates of service) x

16. SOCIAL SECURITY NO. 487-40-5978

17. INFORMANT William Zoff, Address 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) Acute Cerebral Vascular Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH 2-3 hrs.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b) Cerebral Arteriosclerosis — wk.

DUE TO (c) Gen. Arteriosclerosis — wk.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

Hypertension Previous – Cerebral hemorrhage 10 wk. previous

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

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. p.m. Month, Day, Year

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 July 5/1960, to July 23/60 and last saw her alive on 8/20/60

Death occurred at 2 A.M. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Samuel C. Bonney M.D.

22b. ADDRESS 205 E. Elm Wash. Mo

22c. DATE SIGNED 8/24/60

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial

23b. DATE 8/25/60

23c. NAME OF CEMETERY OR CREMATORY Immanuel Lutheran Cemetery,

23d. LOCATION (City, town, or county) Washington, (State) Mo.

24. FUNERAL DIRECTOR Nieburg + Vitt, Inc. ADDRESS Washington, Mo.

25. DATE RECD. BY LOCAL REG. 8/25/60

26. REGISTRAR'S SIGNATURE F. C. Hidmann G. L. C. Hidmann

(Licensed Embalmer's Statement on Reverse Side)

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 Jerome F Swoboda

Licensed Embalmer No. 4507

P. O. Address Washington

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