

U.S. DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-030155

FILED VS
ENDED

SEP 12 1960
Registration District No. 115-116 Primary Registration District No. 3020 Registrar's No. 212

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Franklin</u>		2. USUAL RESIDENCE (Where deceased lived - If institution, Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Franklin</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Washington</u>		Length of stay in 1b <u>30 yrs.</u>	c. CITY OR TOWN <u>Washington</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>St. Francis Hospital</u>		Outside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>513 MacArthur</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>G.</u> Last <u>Narup</u>			4. DATE OF DEATH Month <u>Sept.</u> Day <u>9</u> Year <u>1960</u>	
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</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>1/31/1893</u>	9. AGE (last birthday) <u>67</u>	IF UNDER 1 YEAR Months <u>7</u> Days <u>7</u> Hours <u>8</u> Min.	IF UNDER 24 HR Hours <u>8</u> Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Factory Worker</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Cel. Pipe Factory</u>	11. BIRTHPLACE (City and state or country) <u>Villa Ridge, Mo., U.S.A.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Adolph Narup</u>	13b. MOTHER'S MAIDEN NAME <u>Mary Toben</u>	13c. NAME OF HUSBAND OR WIFE <u>Elizabeth M. Narup</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes - no or unknown) (If yes, give war or dates of service) <u>Yes W.W.I.</u>	16. SOCIAL SECURITY NO. <u>486-16-6272</u>	17. INFORMANT <u>Elizabeth M. Narup, Washington, Mo.</u>
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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>Coronary thrombosis</u>		<u>3 days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Arterio-sclerotic C-U-R Disease</u>	<u>10 yrs.</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) <u>Bronchial asthma, severe</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
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19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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.)
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20c. TIME OF INJURY Hour <u> </u> Month, Day, Year <u> </u>
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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 <u>Washington</u>	COUNTY <u>Franklin</u>	STATE <u>Missouri</u>
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21. I attended the deceased from 2 Sep 60 to 9 Sep 60 and last saw ^{her}him alive on 9 Sep 60
Death occurred at 10:45 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>R. W. Berger, MD</u> (Degree or title)	22b. ADDRESS <u>Washington, Mo.</u>	22c. DATE SIGNED <u>9 Sep 60</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial, Sept. 12, 1960</u>	23b. DATE <u> </u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Francis Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Washington, Missouri</u>
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FUNERAL DIRECTOR <u>Hieburg & Wilcox, Washington, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>9/10/60</u>	26. REGISTRAR'S SIGNATURE <u>F. L. Schidmayer, F. L. Schidmayer</u>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

SEP 15 1960

0961 9 100

SEP 16 1960

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

Lester A. Witt

Licensed Embalmer No. 3254

P. O. Address Washington,

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.