

# FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

20 VS SEP 13 1960

=60-031294

Registration District No. 200 Primary Registration District No. 3041 Registrar's No. 147

STATE FILE NUMBER

|   |  |   |  |   |   |  |  |
|---|--|---|--|---|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Macon</u>   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Mo.</u> b. COUNTY <u>Macon</u> |   |  |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <u>Macon</u>   |  | Length of stay in 1b<br><u>5 Days</u>   |  | c. CITY OR TOWN <u>Macon</u>  |   | Inside Limits<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>   |  |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <u>Samaritan Hosp.</u>   |  |   | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location)<br><u>Riggs St.</u>   |   | Reside on Farm<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  |  |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <u>Frank</u> Middle <u>George</u> Last <u>Magnus</u>  |  |   | 4. DATE OF DEATH<br>Month <u>Aug.</u> Day <u>26</u> Year <u>1960</u>                 |   |   |  |  |
| 5. SEX <u>Male</u>  | 6. COLOR OR RACE <u>White</u>          | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> |  | 8. DATE OF BIRTH <u>5/23/1883</u>   | 9. AGE (last birthday) <u>77</u>                      | IF UNDER 1 YEAR<br>Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>  | IF UNDER 24 HR<br>Hours <u>  </u> Min. <u>  </u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Farmer</u>  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>—</u>   |  | 11. BIRTHPLACE (City and state or country)<br><u>Benick, Mo.</u>  |   | 12. CITIZEN OF WHAT COUNTRY<br><u>U.S.A.</u>   |  |
| 13a. FATHER'S NAME<br><u>Henry Magnus</u>   |  |   | 13b. MOTHER'S MAIDEN NAME<br><u>Louise Meyer</u>                                     |   | 14. NAME OF HUSBAND OR WIFE<br><u>Mathilda Magnus</u> |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><u>No</u>   |  | 16. SOCIAL SECURITY NO.<br><u>498-40-0845</u>   |  | 17. INFORMANT<br><u>Mathilda Magnus</u> Address <u>Macon, Mo.</u>   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u>  |  |   |  |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>4 days</u>  |  |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.<br>DUE TO (b) _____<br>DUE TO (c) _____  |  |   |  |   |   |  |  |
| 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.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |  |
| 19. WAS AUTOPSY PERFORMED?<br>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<br>Hour _____ a.m. _____ p.m.   | Month, Day, Year _____                 |   |  |   |   |  |  |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/><br>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>Aug 22 1960</u> to <u>Aug 26 1960</u> and last saw <sup>her</sup> him alive on <u>Aug 26 1960</u><br>Death occurred at <u>1:40 P.</u> m on the date stated above, and to the best of my knowledge from the causes stated. |  |   |  |   |   |  |  |
| 22a. SIGNATURE (Degree or title)<br><u>Edward Deuel</u> M.D.  |  |   |  | 22b. ADDRESS<br><u>Macon</u>  |   | 22c. DATE SIGNED<br><u>8/29/60</u>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  | 23b. DATE<br><u>Aug 28, '60</u>        | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Woodlawn Cem.</u>  |  | 23d. LOCATION (City, town, or county)<br><u>Macon, Mo.</u>  |   | (State)  |  |
| 24. FUNERAL DIRECTOR<br><u>Lester Hutton</u>  |  | ADDRESS<br><u>Macon, Mo.</u>  |  | 25. DATE RECD. BY LOCAL REG.<br><u>9/2/60</u>   | 26. REGISTRAR'S SIGNATURE<br><u>Arthur Deuel</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 Charles P. Hutton

Licensed Embalmer No. 4577

P. O. Address Macon

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.