

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-031747

FILED VS SEP 7 1960

Registration District No. 314 Primary Registration District No. 4459 Registrar's No. 47

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>St. Clair</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Clair</u>					
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <u>Osceola</u>		Length of stay in 1b <u>2 days</u>		c. CITY OR TOWN <u>Vista</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Osceola Hospital</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 Middle Last <u>Benjamin - Lorentzen</u>				4. DATE OF DEATH Month Day Year <u>Aug; 13, 1960</u>					
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>9/1/88</u>	9. AGE (last birthday) <u>71</u>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Harlan Iowa</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>		
13a. FATHER'S NAME <u>Louis Lorentzen</u>			13b. MOTHER'S MAIDEN NAME <u>Margarette Tannansen</u>			14. NAME OF HUSBAND OR WIFE			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes WW# 1</u>			16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT <u>Mr. C.R. McQuatter, Northwood Ia</u>			Address <u>Iowa</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>Cerebral Vascular Accident</u>							INTERVAL BETWEEN ONSET AND DEATH <u>4 hrs</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)						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 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 Month, Day, Year a.m. p.m.									
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>11 Aug 60</u> to <u>13 Aug 60</u> and last saw him alive on <u>13 Aug 60</u> . Death occurred at <u>5:00 A.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <u>[Signature]</u> (Degree or title) <u>MD</u>				22b. ADDRESS <u>Osceola Mo.</u>			22c. DATE SIGNED <u>13 Aug 60</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>8/15/60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Osceola</u>		23d. LOCATION (City, town, or county) (State) <u>Osceola Missouri</u>					
24. FUNERAL DIRECTOR <u>Goodrich Funeral Home, Osceola Mo</u>				25. DATE RECD. BY LOCAL REG. <u>Aug 27-60</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

J.B. [Signature]

Licensed Embalmer No. 3038

P. O. Address Osceola

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.