

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS SEP 12 1960

-60-033459

STATE FILE NUMBER

Registration District No. 323 Primary Registration District No. 4474 Registrar's No. 32

1. PLACE OF DEATH a. COUNTY <u>SALINE</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>LAFAYETTE</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>SWEET SPRINGS</u>		Length of stay in 1b <u>2 Mo</u>		c. CITY OR TOWN <u>CONCORDIA</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>FORSYTH REST HOME</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>302 MAIN ST.</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>HERMAN</u> Middle <u>H.</u> Last <u>DEHLSCHLAGER</u>				4. DATE OF DEATH Month <u>SEPT</u> Day <u>8</u> Year <u>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 checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 25, 1874</u>	9. AGE (last birthday) <u>85</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 <u>GEN FARMING</u>		11. BIRTHPLACE (City and state or country) <u>LAFAYETTE County Mo</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>FRIEDRICH DEHLSCHLAGER</u>			13b. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			14. NAME OF HUSBAND OR WIFE <u>IDA DEHLSCHLAGER</u> <small>DECEASED</small>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT <u>L.W. DEHLSCHLAGER</u>			Address <u>CONCORDIA, 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>Cerebrovascular Accident</u>							INTERVAL BETWEEN ONSET AND DEATH <u>8 hrs.</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) <u>Cerebral Arteriosclerosis -</u>					<u>70 yrs</u>	
		DUE TO (c) <u>Senile Patient</u>					<u>25 yrs.</u>	
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 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 _____ a.m. _____ p.m.		Month, Day, Year						
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>9-7-60</u> to <u>9-8-60</u> and last saw her alive on <u>9-8-60</u>				Death occurred <u>9-8-60</u> <u>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)				22b. ADDRESS <u>Sweet Springs</u>		22c. DATE SIGNED <u>9-9-60</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>9/12/60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>ST. PAUL'S</u>		23d. LOCATION (City, town, or county) <u>CONCORDIA</u>		23e. (State) <u>MO</u>	
24. FUNERAL DIRECTOR <u>E. S. James</u>			ADDRESS <u>Concordia, Mo</u>		25. DATE RECD. BY LOCAL REG. <u>Sept. 9, 1960</u>		26. REGISTRAR'S SIGNATURE <u>Mary Maskey</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 me _____, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed E. S. James _____

Licensed Embalmer No. 2058

P. O. Address Concordia

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.