

# MARI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS SEP 23 1960 8

59-033815  
STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. 3006 Registrar's No. 532

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Boone</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Columbia</u> Length of stay in 1b <u>16 dys</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Univ. of Mo. Medical Center</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Cole</u> c. CITY OR TOWN <u>Jefferson City</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>803 W. Main</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Mayer Anna</u> Middle <u>Robben</u> Last <u>Mayer</u>			<b>4. DATE OF DEATH</b> Month <u>9</u> Day <u>16</u> Year <u>1960</u>				
<b>5. SEX</b> <u>F.</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. Married</b> <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>10-29-79</u>	<b>9. AGE</b> (last birthday) <u>80</u>	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (City and state or country) <u>Jefferson City, Mo.</u>			
<b>12. CITIZEN OF WHAT COUNTRY</b> <u>U.S. of Am.</u>		<b>13a. FATHER'S NAME</b> <u>John B Robben</u>		<b>13b. MOTHER'S MAIDEN NAME</b> <u>ANNA Holtershinkin</u>			
<b>13c. NAME OF HUSBAND OR WIFE</b> <u>Joseph Meyer</u>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <u>No.</u>		<b>16. SOCIAL SECURITY NO.</b> <u>None.</u>			
<b>17. INFORMANT</b> <u>Univ. of Mo. Medical Records</u> Address _____		<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarct</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					
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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)				
<b>20c. TIME OF INJURY</b> Hour _____ a.m. _____ p.m. Month, Day, Year _____		<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>					
<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>20f. CITY, TOWN, OR LOCATION</b>		COUNTY _____ STATE _____			
<b>21. I attended the deceased from</b> <u>Sept. 10, 1960</u> to <u>Sept. 16, 1960</u> and last saw her alive on <u>Sept. 16, 1960</u> Death occurred at <u>4:00 P</u> m on the date stated above, and to the best of my knowledge, from the causes stated.							
<b>22a. SIGNATURE</b> (Degree or title) <u>John H Landor, M.D.</u>			<b>22b. ADDRESS</b> <u>807 Stadium Rd. Columbia, Mo.</u>		<b>22c. DATE SIGNED</b> <u>9-16-60</u>		
<b>23a. BURIAL, CREMATION, EMERAL (Specify)</b> <u>BURIAL</u>		<b>23b. DATE</b> <u>9/19/60</u>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>St Peter</u>		<b>23d. LOCATION</b> (City, town, or county) (State) <u>Jefferson City, Mo.</u>		
<b>24. FUNERAL DIRECTOR</b> <u>Lynette Dulle</u> ADDRESS _____		<b>25. DATE RECD. BY LOCAL REG.</b> <u>Sept 20 1960</u>		<b>REGISTRAR'S SIGNATURE</b> <u>Mrs R E Palmer</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 \_\_\_\_\_  
*Sylvester Aul*

Licensed Embalmer No. 4321

P. O. Address Jeffersonville

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.