

UNIFORM DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-035300

FILED VS SEP 22 1960/60

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. 5592 Registrar's No. 114

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|--|--------------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>Jefferson</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Jefferson</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Joachim Twp.</u> | Length of stay in 1b <u>20 Years</u> | c. CITY OR TOWN <u>Festus</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>Residence, Route #2, Festus</u> | | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | d. STREET ADDRESS (If outside, give location) <u>Route #2</u> |
| Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | | |

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|---|---------------------------|---|--|--|---|
| 3. NAME OF DECEASED (Type or print) First <u>Philip</u> Middle <u>-----</u> Last <u>Hess</u> | | | 4. DATE OF DEATH Month <u>Sept.</u> Day <u>15,</u> Year <u>1960</u> | | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</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>2/9/1897</u> | 9. AGE (last birthday) <u>63</u> | IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____ |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Structural Steer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Building</u> | 11. BIRTHPLACE (City and state or country) <u>St. Louis, Mo.</u> | 12. CITIZEN OF WHAT COUNTRY <u>USA</u> | |
| 13a. FATHER'S NAME <u>Nicholas Hess</u> | | 13b. MOTHER'S MAIDEN NAME <u>Anna Hess</u> | 14. NAME OF HUSBAND OR WIFE <u>Minnetta Ottinger Hess</u> | | |
| 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>493-09-1408</u> | 17. INFORMANT Address <u>Mrs. Phil Hess, R #2, Festus, 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: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>6 weeks</u> <u>reborn</u> |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | DUE TO (b) <u>mitral insufficiency</u> | |
| | DUE TO (c) _____ | |

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| 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 | |
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| 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 _____ | | | |

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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 | COUNTY | STATE |
|--|--|------------------------------|--------|-------|

21. I attended the deceased from Feb 3, 1960 to date and last saw him alive on Aug 27, 1960
Death occurred at 10:00 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

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| 22a. SIGNATURE <u>[Signature]</u> (Degree or title) | 22b. ADDRESS <u>Congratel City, Mo.</u> | 22c. DATE SIGNED <u>9/16/60</u> |
|---|---|---------------------------------|

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| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u> | 23b. DATE <u>9/20/1960</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Missouri Crematory</u> | 23d. LOCATION (City, town, or county) <u>St. Louis, Mo.</u> |
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| 24. FUNERAL DIRECTOR <u>Vinyard Funeral Homes, Festus, Mo.</u> ADDRESS | 25. DATE RECD. BY LOCAL REG. <u>9/16/60</u> | 26. REGISTRAR'S SIGNATURE <u>[Signature]</u> |
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

NOV 8 1961

APR 5 1961

OCT 7 1960

SEP 28 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 Donald H. Vinyard

Licensed Embalmer No. 46600

P. O. Address Georgetown

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.