

# I DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-035310

ED VS SEP 20 1960

Registration District No. 162 Primary Registration District No. 5594 Registrar's No. 104

STATE FILE NUMBER

<b>1. PLACE OF DEATH</b> a. COUNTY <u>JEFFERSON</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Rural Meramee</u> Length of stay in 1b <u>1 day</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Hillsboro Mo R#1</u> Inside Limits Yes <input 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>WARREN</u> c. CITY OR TOWN <u>Warrenton Mo</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>405 E Walton</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>				
<b>3. NAME OF DECEASED</b> (Type or print) First <u>WALTER</u> Middle <u>J.</u> Last <u>QUIEK</u>				<b>4. DATE OF DEATH</b> Month <u>9</u> - Day <u>6</u> - Year <u>60</u>				
<b>5. SEX</b> <u>m</u>	<b>6. COLOR OR RACE</b> <u>w</u>	<b>7. Married</b> <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>6/24/1890</u>	<b>9. AGE</b> (last birthday) <u>70</u>	<b>IF UNDER 1 YEAR</b> Months _____ Days _____	<b>IF UNDER 24 HR</b> Hours _____ Min. _____		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Retired</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>farmer</u>		<b>11. BIRTHPLACE</b> (City and state or country) <u>Shinland Mo</u>		<b>12. CITIZEN OF WHAT COUNTRY</b> <u>U.S.A.</u>		
<b>13a. FATHER'S NAME</b> <u>Wm Quiek</u>			<b>13b. MOTHER'S MAIDEN NAME</b> <u>Mary Peters</u>			<b>14. NAME OF HUSBAND OR WIFE</b> <u>ESTHER A QUIEK</u>		
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> <u>499-24-8873</u>		<b>17. INFORMANT</b> Address <u>James Weir Hillsboro Mo R#1</u>				
<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>CORONARY Occlusion</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH _____		
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		
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" 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 _____ Month, Day, Year _____ a.m. p.m.		<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>Carver's View</u> and last saw her him alive on _____ Death occurred at <u>4:30 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>James C. Palmer M.C. Corona</u>				<b>22b. ADDRESS</b> <u>Feather Mo.</u>		<b>22c. DATE SIGNED</b> <u>9/6/60</u>		
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Removal</u>		<b>23b. DATE</b> <u>9-9-60</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>St. Joseph Cem.</u>		<b>23d. LOCATION</b> (City, town, or county) (State) <u>Shinland Mo</u>		
<b>24. FUNERAL DIRECTOR</b> ADDRESS <u>T.W. Nickburg &amp; Co Warrenton Mo</u>				<b>25. DATE RECD. BY LOCAL REG.</b> <u>9-9-60</u>		<b>26. REGISTRAR'S SIGNATURE</b> <u>Robert E. Bauer</u>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

FEB 6 1961

SEP 21 1960

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Herbert J. Law Jr.

Licensed Embalmer No. 480

P. O. Address Hickwood

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to  
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.