

FEDERAL BUREAU OF INVESTIGATION  
**FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**-60-035415**

FILED VS SEP 26 1960 179

Registration District No. \_\_\_\_\_ Primary Registration District No. **5667**

Registrar's No. **123**

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>Lincoln</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Lincoln</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Bedford Twp.</b>		c. CITY OR TOWN <b>Troy</b>	
Length of stay in 1b		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Lincoln Co. Mem. Hosp.</b>		d. STREET ADDRESS (If outside, give location) <b>No St. Address</b>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Henry</b> Last <b>Muensterman</b>			4. DATE OF DEATH Month <b>September</b> Day <b>17</b> Year <b>1960</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>3/27/67</b>
9. AGE (last birthday) <b>93</b>		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) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Gen. Farming</b>	11. BIRTHPLACE (City and state or country) <b>Syke, Germany</b>
12. CITIZEN OF WHAT COUNTRY <b>USA</b>		13a. FATHER'S NAME <b>John Fredrick Muensterman</b>	
13b. MOTHER'S MAIDEN NAME <b>Margarite Koenigkam</b>		14. NAME OF HUSBAND OR WIFE <b>Rosa Scheidegger Muensterman</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>495-44-5776</b>	17. INFORMANT <b>Oscar Muensterman, Troy, Missouri.</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebro-Vascular Accident</b>  DUE TO (b) <b>Senility</b>  DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <b>Approx. 24 Hours</b>
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 _____ 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 <b>8/10 - 60.</b> to <b>9/17/60</b> and last saw him alive on <b>9/17/60</b>		Death occurred at <b>1:30 AM</b> on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE <i>John Henry Muensterman M.D.</i> (Degree or title)		22b. ADDRESS <b>Troy, Missouri.</b>	22c. DATE SIGNED <b>9/18/60</b>
23a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>9/19/60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Evangelical Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Troy, Missouri.</b>
24. FUNERAL DIRECTOR <b>Kemper-Marsh Funeral Home, Troy, Mo.</b>	ADDRESS	25. DATE RECD. BY LOCAL REG. <b>9-19-1960</b>	26. REGISTRAR'S SIGNATURE <i>Charlotte Leek</i>

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 Joseph F. Marshall

Licensed Embalmer No. 5105

P. O. Address Troy, Missouri

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.