

REGISTRATION DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-035869

FILED VS OCT 11 1960

Registration District No. 316 Primary Registration District No. \_\_\_\_\_ Registrar's No. 390

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>St. Francois</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>St. Francois</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>DESLAGE, MO.</u>		c. CITY OR TOWN <u>DESLAGE, MO.</u>	
Length of stay in lb		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION		d. STREET ADDRESS (If outside, give location) <u>MAIN ST.</u>	
Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>Katherine</u> Middle <u>Louise</u> Last <u>Qualls</u>			4. DATE OF DEATH Month <u>Oct</u> Day <u>7</u> Year <u>1960</u>				
5. SEX <u>FEMALE</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>JULY 8, 1878</u>	9. AGE (last birthday) <u>82</u>	IF UNDER 1 YEAR Months _____ Days _____		
10a. USUAL OCCUPATION (Give kind of work done during last 12 months, even if retired) <u>RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RETIRED</u>		11. BIRTHPLACE (City and state or country) <u>IRON MT. MO.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>BENJAMIN WEITZEL</u>		13b. MOTHER'S MAIDEN NAME <u>ELIZABETH BLATTNER.</u>		14. NAME OF HUSBAND OR WIFE <u>GEORGE QUALLS</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, name of unknown) (If yes, give war or dates of service) <u>No.</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>MR. PAUL QUALLS</u> Address <u>DESLAGE, 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>Arterio sclerotic heart disease</u>		INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b) <u>generalized arterio sclerosis</u>		
DUE TO (c)		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Diabetes mellitus</u>		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

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 1959 to Oct 7, '60 and last saw her him alive on Oct 7, 1960  
Death occurred at 2:30 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>J.L. Foster</u> (Degree or title) <u>MS</u>		22b. ADDRESS <u>Deslage Mo</u>		22c. DATE SIGNED <u>Oct 8, 60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>10-10-60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>PARKVIEW CEM.</u>	
24. FUNERAL DIRECTOR <u>R. Kaldwell &amp; Sons</u> ADDRESS <u>FLAT RIVER, MO.</u>		25. DATE RECD. BY LOCAL REG. <u>Oct. 10, 1960</u>		26. REGISTRAR'S SIGNATURE <u>Eather Rudloff</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 Donald Dale Caldwell

Licensed Embalmer No. 5095

P. O. Address Flat River,

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.