

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-037952
STATE FILE NUMBER

FILED VS. OCT 31 1960 115-116

Registration District No. _____ Primary Registration District No. 3020 Registrar's No. 232

ENDED

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|---|--|---|--|--|---|---|--|--|
| 1. PLACE OF DEATH a. COUNTY Franklin. | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Franklin. | | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Washington. | | Length of stay in 1b 6 hrs. | | c. CITY OR TOWN Villa Ridge | | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Francis Hospital | | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) R. R. | | Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) First Elizabeth Middle C. Last Hellmann | | | | 4. DATE OF DEATH Month October Day 23, Year 1960. | | | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 11/21/1898 | 9. AGE (last birthday) 61 | IF UNDER 1 YEAR Months 11 Days 2 | IF UNDER 24 HR Hours Min. | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife. | | | 10b. KIND OF BUSINESS OR INDUSTRY x | | 11. BIRTHPLACE (City and state or country) Union, Missouri. | | 12. CITIZEN OF WHAT COUNTRY U. S. A. | |
| 13a. FATHER'S NAME Conrad Hellmann. | | | 13b. MOTHER'S MAIDEN NAME Mary Heckelmann. | | 14. NAME OF HUSBAND OR WIFE Louis C. Hellmann. | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No. | | | 16. SOCIAL SECURITY NO. None. | 17. INFORMANT Address R. F. D. Villa Ridge, Mo. Louis C. Hellmann | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Surgical Shock & Toxicity DUE TO (b) Staphylococcal septicemia DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | | | | | INTERVAL BETWEEN ONSET AND DEATH 8 hours 2 days. | | |
| 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 | | |
| 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 _____ Month, Day, Year _____ a.m. _____ p.m. _____ | | 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 Oct 23, 1960 to Oct 23, 1960 and last saw her alive on Oct 23, 1960 Death occurred at 5:00 a.m. on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | | |
| 22a. SIGNATURE (Degree or title) L. G. Muenner M.D. | | | | 22b. ADDRESS 905 Elm Washington Mo | | 22c. DATE SIGNED 10/25/60 | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE Oct. 26, 1960. | 23c. NAME OF CEMETERY OR CREMATORY St. John's Cemetery, (Gildehaus) | | 23d. LOCATION (City, town, or county) Villa Ridge, Mo. R.R. | | (Sign) | |
| 24. FUNERAL DIRECTOR Nieburg & Vitt, Inc., | | | ADDRESS Washington, Mo. | 25. DATE RECD. BY LOCAL REG. 10/25/60 | 26. REGISTRAR'S SIGNATURE L. G. Muenner | | | |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

0961 1 AON

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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

Lester A. Vitt

Licensed Embalmer No. 3254

P. O. Address Washington

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.