

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-037955

FILED VS OCT 24 1960

Registration District No. 115-116 Primary Registration District No. 3030 Registrar's No. 327

STATE FILE NUMBER

INDEXED

1. PLACE OF DEATH a. COUNTY <u>FRANKLIN</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>FRANKLIN</u>									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>WASHINGTON</u>		Length of stay in lb		c. CITY OR TOWN <u>UNION</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>							
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ST. FRANCIS HOSPITAL</u>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>R.R.#1</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <u>NORA</u> Middle <u>PURSCHE</u> Last <u>PURSCHE</u>				4. DATE OF DEATH Month <u>OCTOBER</u> Day <u>14</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>8/17/1885</u>		9. AGE (last birthday) <u>75</u>		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) <u>HOUSEWORK</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>HOUSEWIFE</u>		11. BIRTHPLACE (City and state or country) <u>ST. CLAIR, MISSOURI</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>					
13a. FATHER'S NAME <u>ALBERT FRANK</u>				13b. MOTHER'S MAIDEN NAME <u>BRUEGGEMANN</u>				14. NAME OF HUSBAND OR WIFE <u>JOSEPH PURSCHE</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>NONE</u>		17. INFORMANT <u>ROBERT PURSCHE</u> Address <u>UNION, MISSOURI</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>Encephalopathy due to</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>arterio-sclerotic changes in vessels</u> DUE TO (c) <u>stroke</u>										INTERVAL BETWEEN ONSET AND DEATH <u>15 days</u>			
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 <u>          </u> Month, Day, Year <u>          </u> 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 <u>10/11/60</u> to <u>10/14/60</u> and last saw her/him alive on <u>10/14/60</u> Death occurred at <u>7:30 P.M.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE (Degree or title) <u>[Signature]</u>						22b. ADDRESS <u>Union Mo</u>			22c. DATE SIGNED <u>10/15/60</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>10/17/1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>IMMACULATE CONCEPTION</u>		23d. LOCATION (City, town, or county) <u>UNION</u>		STATE <u>MISSOURI</u>					
24. FUNERAL DIRECTOR <u>OLTMANN FUNERAL HOME</u> ADDRESS <u>UNION, MISSOURI</u>				25. DATE RECD. BY LOCAL REG. <u>10/17/60</u>		26. REGISTRAR'S SIGNATURE <u>[Signature]</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 Ralph Altman

Licensed Embalmer No. 4808

P. O. Address Union, Mo

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.