

# IRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS NOV 7 1960

60-037987

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 1087A

STATE FILE NUMBER

INDEXED

1. PLACE OF DEATH a. COUNTY <u>GREENE</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>WEBSTER</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>SPRINGFIELD</u>	Length of stay in lb <u>4 DAYS</u>	c. CITY OR TOWN <u>MARSHFIELD</u>	Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ST JOHNS Hosp.</u>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>4 mi S.W.</u>	Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Louis</u> Middle <u>D</u> Last <u>ANDREATA</u>	4. DATE OF DEATH Month <u>OCT</u> Day <u>27</u> Year <u>1960</u>
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5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>10-23-1894</u>	9. AGE (last birthday) <u>66</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETFARMER</u>	10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (City and state or country) <u>MISSOURI</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A</u>
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13a. FATHER'S NAME <u>SAM ANDREATA</u>	13b. MOTHER'S MAIDEN NAME <u>ANGELINE DEPETCH</u>	14. NAME OF <del>HUSBAND</del> WIFE <u>EDNA</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war, or date of service) <u>YES WWI</u>	16. SOCIAL SECURITY NO. _____	17. INFORMANT Address <u>EDNA ANDREATA MARSHFIELD</u>
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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>Cerebral hemorrhage involving pons</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ 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>Pneumonitis, terminal</u>	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
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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.) <u>—</u>
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	Month, Day, Year <u>—</u>
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20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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 _____
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21. I attended the deceased from 24 October 1960 to 27 Oct. 1960 and last saw <sup>her</sup>him alive on 26 Oct 1960  
Death occurred at 9:25 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Daniel E. Holmes M.D.</u>	22b. ADDRESS <u>600 S. Glenstone, Springfield</u>	22c. DATE SIGNED <u>31 Oct 60</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	23b. DATE <u>10-27-1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MARSHFIELD</u>	23d. LOCATION (City, town, or county) (State) <u>MARSHFIELD MO</u>
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24. FUNERAL DIRECTOR <u>BARBER-EDWARDS</u>	ADDRESS <u>MARSHFIELD</u>	25. DATE RECD. BY LOCAL REG. <u>11-1-1960</u>	26. REGISTRAR'S SIGNATURE <u>Effie S. Melton</u>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

NOV 7 1960

NOV 15 1960

**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

*George Stokje*

Licensed Embalmer No. 7661

P. O. Address Mr. Brown

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.