

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-040894

FILED VS NOV 28 1960

Registration District No. 1 Primary Registration District No. 3000 Registrar's No. 337

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY Adair				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Adair				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kirksville		Length of stay in 1b 14 years		c. CITY OR TOWN Kirksville		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Kirksville Osteopath. Hosp.			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 816 E. McPherson		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Ross Robert Hoerrmann				4. DATE OF DEATH Month Day Year November 21, 1960				
5. SEX male	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 12/22/1888	9. AGE (last birthday) 71	IF UNDER 1 YEAR Months 10 Days 29 Hours Min. 	IF UNDER 24 HR Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired farmer			10b. KIND OF BUSINESS OR INDUSTRY farming		11. BIRTHPLACE (City and state or country) Adair Co., Mo.		12. CITIZEN OF WHAT COUNTRY U. S. A.	
13a. FATHER'S NAME Ferdinand Hoerrmann			13b. MOTHER'S MAIDEN NAME Celesta Miller		14. NAME OF HUSBAND OR WIFE Grace (Snyder) Hoerrmann			
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. 497-32-1422		17. INFORMANT Address Orville Hoerrmann-Kirksville, Mo.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Medullary Paralysis DUE TO (b) Cerebral thrombosis DUE TO (c) arteriosclerosis Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. 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							INTERVAL BETWEEN ONSET AND DEATH Hours Days Years	
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 3-2-59 to 11-21-60 and last saw ^{her} him live on 11-21-60 Death occurred at 4:37 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) Lyle A. Parker, M.D.				22b. ADDRESS Kirksville Mo		22c. DATE SIGNED 11-22-60		
23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE 11/23/60	23c. NAME OF CEMETERY OR CREMATORY Ringo Point Cemetery		23d. LOCATION (City, town, or county) Adair Co., Mo.		23e. (State)		
24. FUNERAL DIRECTOR ADDRESS Dee Riley Funeral Home, Inc. Kirksville, Mo. Larry K. Jackson				25. DATE RECD. BY LOCAL REG. 11-23-1960		26. REGISTRAR'S SIGNATURE Doris W. Battiff		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

DEC 2 1960

LYLE P PARTIN, D.O.

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 Kenneth W. Hayes

Licensed Embalmer No. 4890

P. O. Address Kenneth W. Hayes

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.