

REGISTRATION DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-040939

FILED VS NOV 28 1960

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Primary Registration District No. 5037

Registrar's No. 272

STATE FILE NUMBER

INDEXED

1. PLACE OF DEATH a. COUNTY <u>Audrain</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> COUNTY <u>Callaway</u>						
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Salt River Twp</u>		Length of stay in lb <u>44 days</u>		c. CITY OR TOWN <u>Fulton</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>Coldwold Nursing Home</u>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>808 Court St.</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Ella</u> Middle <u>Wolz</u> Last <u>Wolz</u>				4. DATE OF DEATH Month <u>Nov.</u> Day <u>22</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 checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>10-18-1878</u>	9. AGE (last birthday) <u>87</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HR Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (City and state or country) <u>Mascoutah, Illinois</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>			
13a. FATHER'S NAME <u>John Wolz</u>			13b. MOTHER'S MAIDEN NAME <u>Alwina Friess</u>			14. NAME OF HUSBAND OR WIFE <u>Single</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 Address <u>Miss Rose Wolz, Coldwell Nursing Hm</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:						MEXICO, MO		INTERVAL BETWEEN ONSET AND DEATH		
IMMEDIATE CAUSE (a) <u>Circulatory Failure</u>								<u>3 hrs</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Coronary Failure</u>								<u>3 days</u>		
DUE TO (c) <u>Myocarditis Chronic</u>								<u>yes</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 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>										
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>11-22-60</u> to <u>11-22-60</u> and last saw her <u>live</u> on <u>11-22-60</u> Death occurred at <u>11:15 A.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.										
22a. SIGNATURE (Degree or title) <u>W. K. Kellerman M.D.</u>				22b. ADDRESS <u>Mexico, Mo.</u>			22c. DATE SIGNED <u>11-23-60</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>Nov, 23, 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Cemetery</u>			23d. LOCATION (City, town, or county) (State) <u>Fulton Missouri</u>				
24. FUNERAL DIRECTOR ADDRESS <u>Wallace Funeral Home, Fulton, Mo.</u>				25. DATE RECD. BY LOCAL REG. <u>Nov 23-1960</u>		26. REGISTRAR'S SIGNATURE <u>Blanche Neely</u>				

(Licensed Embalmer's Statement on Reverse Side)

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 Wenzil C Browning

Licensed Embalmer No. 2724

P. O. Address Fullon,

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.