

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-041754

FILED VS NOV 21 1960

Registration District No. 137 Primary Registration District No. 3023 Registrar's No. 287 STATE FILE NUMBER

DED

| | | | | | | | | |
|---|--|---|--|---|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Henry</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>LaFayette</u> | | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Clinton</u> | | Length of stay in 1b <u>10 DAYS</u> | | c. CITY OR TOWN <u>Higginsville</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Wetzel Osteo. Hosp.</u> | | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) <u>1510 WALNUT</u> | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>R</u> Last <u>Luehrs.</u> | | | | 4. DATE OF DEATH Month <u>Nov</u> Day <u>12</u> Year <u>1960</u> | | | | |
| 5. SEX <u>M.</u> | 6. COLOR OR RACE <u>W</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>Aug. 31, 1894</u> | 9. AGE (last birthday) <u>65</u> | IF UNDER 1 YEAR Months <u>2</u> Days <u>11</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>AUTO & IMP DEALER</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>AUTO & IMP DEALER</u> | | 11. BIRTHPLACE (City and state or country) <u>HIGGINSVILLE MO.</u> | | 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> | | |
| 13a. FATHER'S NAME <u>HENRY LUEHRS</u> | | | 13b. MOTHER'S MAIDEN NAME <u>AMELIA SEMMLER</u> | | 14. NAME OF HUSBAND OR WIFE <u>FLOSSIE LUEHRS</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>yes</u> | | 16. SOCIAL SECURITY NO. <u>497-36-7086</u> | | 17. INFORMANT <u>FLOSSIE LUEHRS HIGGINSVILLE</u> | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> | |
| IMMEDIATE CAUSE (a) <u>Bronchiopneumonia</u> | | | | | | | <u>3 days</u> | |
| DUE TO (b) <u>cardiac failure</u> | | | | | | | <u>10 days</u> | |
| DUE TO (c) <u>hepatic cirrhosis</u> | | | | | | | <u>6 mo</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 checked="" 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> a.m. <u>-</u> p.m. <u>-</u> | | Month, Day, Year | | | | | | |
| 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>November 9, 1960</u> to <u>November 12, 1960</u> and last saw ^{her} him alive on <u>Nov. 12, 1960</u> Death occurred at <u>4:45</u> p.m. on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | | |
| 22a. SIGNATURE (Degree or title) <u>Edwin Wilson D.O.</u> | | | | 22b. ADDRESS <u>1815 Main Higginsville Mo.</u> | | 22c. DATE SIGNED <u>11/12/60</u> | | |
| 23a. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u> | 23b. DATE <u>11-15-60</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>HIGGINSVILLE</u> | | 23d. LOCATION (City, town, or county) (State) <u>HIGGINSVILLE MO.</u> | | | | |
| 24. FUNERAL DIRECTOR <u>F.L. SCHABERG</u> | | | ADDRESS <u>CLINTON, MO</u> | 25. DATE RECD. BY LOCAL REG. <u>Nov. 15 1960</u> | | 26. REGISTRAR'S SIGNATURE <u>Mildred Bigum</u> | | |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

VS DEC 5 1960

NOV 22 1960

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed F. L. Schoenberg

Licensed Embalmer No. 451

P. O. Address Clinton

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to
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.