

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-041755

FILED VS NOV 21 1960

Registration District No. 137 Primary Registration District No. 3023 Registrar's No. 284

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>Henry</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo</b> b. COUNTY <b>PETTIS</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>CLINTON</b>		Length of stay in 1b <b>9 days</b>	c. CITY OR TOWN <b>SEDALIA</b> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>WETZEL OSTEOPATHIC</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>ROUTE 1</b> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <b>JOHN (NOVE) MALTSBARGER</b>			4. DATE OF DEATH Month Day Year <b>NOVEMBER 11 1960</b> <del>NOVEMBER 21 1953</del>		
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>11/20/93</b>	9. AGE (last birthday) <b>67</b>	IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>AGRICULTURE</b>	11. BIRTHPLACE (City and state or country) <b>SEDALIA, MISSOURI</b>	12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13a. FATHER'S NAME <b>MICHAEL P. MALTSBARGER</b>		13b. MOTHER'S MAIDEN NAME <b>ROSA LEE KEELE</b>		14. NAME OF HUSBAND OR WIFE <b>FLOSSIE MALTSBARGER</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>FLOSSIE MALTSBARGER (WIFE) SEDALIA, PETTIS, MO</b>	

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
IMMEDIATE CAUSE (a) <b>Myocardial infarction</b>		<b>30 min.</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Coronary occlusion</b>	<b>9 days</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) <b>None</b>	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> N- <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.)
20c. TIME OF INJURY Hour a.m. p.m.	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 **NOV 2, 1960** to **NOV 11, 1960** and last saw <sup>her</sup> him alive on **NOV 11, 1960**  
Death occurred at **10:38 AM, Nov 11, 1960** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <b> Gus J. Vogel D.D.</b>		22b. ADDRESS <b>105 E OHIO, CLINTON, MO.</b>		22c. DATE SIGNED <b>Nov 11, 1960</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>11-14-1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Crown Hill</b>	23d. LOCATION (City, town, or county) (State) <b>Sedalia Mo</b>	
24. FUNERAL DIRECTOR ADDRESS <b>McLaughlin Bros Sedalia</b>		25. DATE RECD. BY LOCAL REG. <b>Nov 14, 1960</b>	26. REGISTRAR'S SIGNATURE <b>Mildred Bigum</b>	

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

MAR 2 8 1934

**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 K. P. M. L.rary

Licensed Embalmer No. 3153

P. O. Address Sedalia

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.