

# RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-043051

FILED VS DEC 6 1960

Registration District No. 274 Primary Registration District No. 3057 Registrar's No. 395

STATE FILE NUMBER

DED

1. PLACE OF DEATH a. COUNTY <u>Pettis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>Pettis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Washington Township</u>		Length of stay in lb <u>Life</u>	c. CITY OR TOWN <u>Washington Township</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>5 Mi W Cole Camp Mo</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>5 Mi W Cole Camp Mo</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>- -</u> Last <u>Miesner</u>			4. DATE OF DEATH Month <u>Nov</u> Day <u>22</u> , Year <u>1960</u>
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>9/15/99</u>
9. AGE (last birthday) <u>61</u>		IF UNDER 1 YEAR Months <u>    </u> Days <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>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Agriculture</u>	11. BIRTHPLACE (City and state or country) <u>Missouri</u>
12. CITIZEN OF WHAT COUNTRY <u>U S A</u>		13a. FATHER'S NAME <u>Claus Miesner</u>	
13b. MOTHER'S MAIDEN NAME <u>Anna Harms</u>		14. NAME OF HUSBAND OR WIFE <u>Mrs Emma Miesner</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>- - - - -</u>	
17. INFORMANT <u>Glen Miesner</u>		Address <u>Ionia Mo</u>	
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>Carcinoma, rt kidney -</u>			INTERVAL BETWEEN ONSET AND DEATH <u>9 mo -</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)		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 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 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 _____
21. I attended the deceased from <u>April 19, 1960</u> to <u>Nov-17, 1960</u> and last saw him alive on <u>Nov-17, 1960</u> . Death occurred at <u>Nov 22, 1960 3:30 P</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>John E Larry MD</u>		22b. ADDRESS <u>1609 S. Summit Sedalia Mo</u>	22c. DATE SIGNED <u>11/25/60</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>11-25-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St Johns Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Benton County Mo</u>
24. FUNERAL DIRECTOR <u>E L Eickhoff Cole Camp Mo</u>		25. DATE RECD. BY LOCAL REG. <u>11-27-1960</u>	26. REGISTRAR'S SIGNATURE <u>Frances Shelby</u>

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 E L Eickhoff  
E L Eickhoff

Licensed Embalmer No. 730

P. O. Address Cole Camp M

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.