

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH
FILED VS DEC 28 1960

-60-045015

STATE FILE NUMBER

Registration District No. 4 Primary Registration District No. _____ Registrar's No. 248

1. PLACE OF DEATH a. COUNTY <u>Atchison</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Atchison</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Fairfax</u>		Length of stay in 1b <u>3 wks</u>	c. CITY OR TOWN <u>Rock Port</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Fairfax Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>Clay Twzp.</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Rudolph</u> Middle <u>Alfred</u> Last <u>Fox</u>			4. DATE OF DEATH Month <u>12</u> Day <u>21</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>3-24-1887</u>	9. AGE (last birthday) <u>73</u>	IF UNDER 1 YEAR IF UNDER 24 HR Months <u>8</u> Days <u>27</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Agriculture</u>		11. BIRTHPLACE (City and state or county) <u>Atchison Co., Mo.</u>		
13a. FATHER'S NAME <u>Michael Fox.</u>		13b. MOTHER'S MAIDEN NAME <u>Henerietta Vogler</u>		14. NAME OF HUSBAND OR WIFE <u>Ora Fox</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>496-42-3993</u>	17. INFORMANT <u>Mrs Ora Fox</u> Address <u>Rock Port,</u>
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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) <u>Aspiration pneumonia</u>		<u>2 days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Cerebrovascular accident</u>	<u>1 month</u>
	DUE TO (c) <u>Arteriosclerosis</u>	<u>years</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"/> N. <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 <u></u> a.m. <u></u> p.m. <u></u> Month, Day, Year <u></u>		

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>10/60</u> to <u>12/20/60</u> and last saw her/him alive on <u>12/20/60</u> Death occurred at <u>1:00 am</u> on the date stated above, and to the best of my knowledge, from the causes stated.		

22a. SIGNATURE (Degree or title) <u>John M. Wenzemaker, M.D.</u>		22b. ADDRESS <u>Rock Port, Mo</u>	22c. DATE SIGNED <u>12/22/60</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>12-23-1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Greenhill Cem.</u>	23d. LOCATION (City, town, or county) (State) <u>Rock Port, Mo.</u>
24. FUNERAL DIRECTOR <u>Bartholomew Mortuary, Rock Port.</u> ADDRESS <u></u>	25. DATE RECD. BY LOCAL REG. <u>Dec 23, 1960</u>	26. REGISTRAR'S SIGNATURE <u>Thermin J. Schuler</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

Grady Barshatman

Licensed Embalmer No. 2173

P. O. Address Rock Pt

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.