

**JURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

FILED VS DEC 27 1960 *77*

**=60-045532**

STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. *3016* Registrar's No. *436*

ENDED

|   |  |   |  |  |  |  |  |  |
|---|--|---|--|--|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <i>Cole</i>  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <i>MO.</i> b. COUNTY <i>Gasconade</i>                  |  |  |  |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>Jefferson City</i>   |  | Length of stay in 1b <i>7 days</i>  |  | c. CITY OR TOWN <i>Owensville</i>  |  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>   |  |  |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>St. MARY'S Hospital</i>  |  |   |  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>   |  | d. STREET ADDRESS (If outside, give location)<br><i>411 S. 5<sup>th</sup> St.</i>  |  |  |
| 3. NAME OF DECEASED (Type or print) First <i>CLARA</i> Middle <i>CORTNA</i> Last <i>SASSMANN</i>  |  |   |  | 4. DATE OF DEATH Month <i>Dec.</i> Day <i>21</i> Year <i>1960</i>  |  |  |  |  |
| 5. SEX <i>Female</i>  |  | 6. COLOR OR RACE <i>White</i>   |  | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> |  | 8. DATE OF BIRTH <i>8-29-90</i>  |  |  |
| 9. AGE (last birthday) <i>70</i>  |  | IF UNDER 1 YEAR<br>Months _____ Days _____  |  | IF UNDER 24 HR<br>Hours _____ Min. _____   |  |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>  |  |   | 10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>  |  | 11. BIRTHPLACE (City and state or country) <i>Humansville Mo</i> |  | 12. CITIZEN OF WHAT COUNTRY <i>U. S. A.</i>      |  |
| 13a. FATHER'S NAME <i>ANDREW MILLER</i>   |  |   | 13b. MOTHER'S MAIDEN NAME <i>ALICE Souders</i> |  |  | 14. NAME OF HUSBAND OR WIFE <i>Edward SASSMANN</i>   |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i>  |  |   | 16. SOCIAL SECURITY NO. <i>494-09-6703A</i>    |  | 17. INFORMANT <i>EDWARD SASSMANN</i>                             |  | Address <i>Owensville Mo</i>                     |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Carcinoma of stomach</i><br>DUE TO (b) _____<br>DUE TO (c) _____<br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. |  |   |  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH-<br><i>1 yr</i> |  |
| PART II. OTHER SIGNIFICANT CONDITIONS, CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>hemorrhage</i>  |  |   |  |  |  | PART III. If deceased was female was there a pregnancy in last 90 days.<br><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 _____ 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 _____ to _____ 1960 and last saw her/him alive on <i>12/21/60</i><br>Death occurred at <i>4:30 P.M.</i> on the date stated above, and to the best of my knowledge, from the causes stated.   |  |   |  |  |  |  |  |  |
| 22a. SIGNATURE (Degree or title) <i>Ernest P. Gottenstroeter M.D.</i>   |  |   |  | 22b. ADDRESS <i>Jefferson City, Mo</i>   |  | 22c. DATE SIGNED <i>12/21/60</i>   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>   |  | 23b. DATE <i>DEC. 24, 1960</i>  |  | 23c. NAME OF CEMETERY OR CREMATORY <i>ST PETER'S E+R CEMETERY</i>  |  | 23d. LOCATION (City, town, or county) (State) <i>Owensville Mo.</i>  |  |  |
| 24. FUNERAL DIRECTOR <i>Gottenstroeter Funeral Home</i>   |  |   |  | 25. DATE RECD. BY LOCAL REG. <i>24 December 1960</i>   |  | 26. REGISTRAR'S SIGNATURE <i>R. P. Davis, M.D. - Richter, Dep.</i>   |  |  |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

*Michael H. White* Owensville Mo.  
(Licensed Embalmer's Statement on Reverse Side)

JAN 12 1961

VS JAN 1961

**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 Jerry A. Thompson, Student Embalmer No. 624  
working under my personal supervision.

Student Jerry A. Thompson  
Signature of Student Embalmer

Signed Milford H. H. W.

Licensed Embalmer No. 383

P. O. Address OWENS U

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.