

## FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-045549

FILED VS DEC 19 1960

Registration District No. 82 Primary Registration District No. 3017 Registrar's No. 183

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>Cooper</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Howard</b>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Boonville</b>		Length of stay in 1b <b>2 days</b>		c. CITY OR TOWN <b>New Franklin</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Josephs Hospital</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS <b>102 West Broadway</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>Matilda</b> Middle <b>Dothage</b> Last <b>Klusmeyer</b>				4. DATE OF DEATH Month <b>December</b> Day <b>13</b> Year <b>1960</b>					
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>July 18, 1879</b>	9. AGE (last birthday) <b>81</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Self</b>		11. BIRTHPLACE (City and state or country) <b>Warrenton, Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>		
13a. FATHER'S NAME <b>William Dothage</b>			13b. MOTHER'S MAIDEN NAME <b>Louise Marie Meyer</b>			14. NAME OF HUSBAND OR WIFE <b>Charles Klusmeyer</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. <b>None</b>		17. INFORMANT <b>Mrs. Monte Shields</b> Address <b>New Franklin</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardio infarction</b>							INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>coronary arteriosclerosis</b>							11-24-60		
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. _____									
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 <b>12-11-60</b> to <b>12-13-60</b> and last saw him/her alive on <b>12-13-60</b> Death occurred at <b>7:30 P</b> m on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <i>William A. Dothage, MD</i>				22b. ADDRESS <b>329 Main St. Boonville, Missouri</b>			22c. DATE SIGNED <b>12-15-60</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>Dec. 16, 1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Pleasant</b>			23d. LOCATION (City, town, or county) (State) <b>New Franklin Mo.</b>				
24. FUNERAL DIRECTOR <b>Markland Hall</b> ADDRESS <b>New Franklin, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>12/15/60</b>		26. REGISTRAR'S SIGNATURE <i>Dothage</i>					

(Licensed Embalmer's Statement on Reverse Side)

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 Tom D. Markland

Licensed Embalmer No. 4592  
P. O. Address New Franklin

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.