

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-048392

FILED VS DEC 19 1960

STATE FILE NUMBER

Registration District No. 319 Primary Registration District No. 4469 Registrar's No. 56

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| 1. PLACE OF DEATH a. COUNTY <u>STE. GENEVIEVE</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>STE. GENEVIEVE</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>STE. GENEVIEVE</u> | | Length of stay in lb <u>38 YRS</u> | c. CITY OR TOWN <u>STE. GENEVIEVE</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>4th & WASHINGTON</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) <u>4th WASHINGTON</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

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| 3. NAME OF DECEASED (Type or print) First <u>JOSEPH</u> Middle <u>M.</u> Last <u>BADER</u> | 4. DATE OF DEATH Month <u>DEC</u> Day <u>11</u> Year <u>1960</u> |
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| 5. SEX <u>MALE</u> | 6. COLOR OR RACE <u>WHITE</u> | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>9/29/71 89</u> | 9. AGE (last birthday) <u>89</u> | IF UNDER 1 YEAR Months _____ Days _____ | IF UNDER 24 HR Hours _____ Min. _____ |
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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED FARMER</u> | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (City and state or country) <u>STE. GENEVIEVE</u> | 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> |
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| 13a. FATHER'S NAME <u>JOSEPH BADER</u> | 13b. MOTHER'S MAIDEN NAME <u>MARY DEWITTS</u> | 14. NAME OF HUSBAND OR WIFE <u>LENA DALLAS</u> |
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| 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>NONE</u> | 17. INFORMANT <u>Edward J. Bader REI St. Genevieve Mo</u> Address _____ |
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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>Acute Coronary Thrombosis</u> | DUE TO (b) <u>Arteriosclerosis</u> | <u>Immediate</u> |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | DUE TO (c) _____ | <u>20 years</u> |

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| 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 |
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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.) |
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| 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 |
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| 21. I attended the deceased from <u>Nov. 2, 1960</u> to <u>Dec. 11, 1960</u> and last saw him alive on <u>Nov. 26, 1960</u> Death occurred at <u>8:00 a.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated. |
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| 22a. SIGNATURE <u>Rob. Lanning M.D.</u> (Degree or title) | 22b. ADDRESS <u>St. Genevieve Mo</u> | 22c. DATE SIGNED <u>12/12/60</u> |
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| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE <u>12/14/60</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>VALLE SPRING</u> | 23d. LOCATION (City, town, or county) <u>STE. GENEVIEVE MO</u> |
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| 24. FUNERAL DIRECTOR <u>Geo. C. Bader St. Genevieve Mo</u> ADDRESS _____ | 25. DATE RECD. BY LOCAL REG. <u>12/13/60</u> | 26. REGISTRAR'S SIGNATURE <u>Keith Bader</u> |
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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 me
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed *Adrian J. Phillips*

Licensed Embalmer No. 4740

P. O. Address St. James

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.