

DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-048434

LED VS JAN 13 1961

Registration District No. 333 Primary Registration District No. 3074 Registrar's No. 2 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Scott</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>SCOTT</u>						
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Sikeston</u>		Length of stay in 1b		c. CITY OR TOWN <u>SIKESTON</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				
c. FULL NAME OF (If NOT in hospital, give location) <del>HOSPITAL</del> OR INSTITUTION <u>Mo. Delta Community</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>409 COLEMAN</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>Carl</u> Last <u>Kiehne</u>				4. DATE OF DEATH Month <u>12</u> Day <u>23</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>11-23-1890</u>	9. AGE (last birthday) <u>70</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during rest of working life, even if retired) <u>RET.</u>			10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (City and state or country) <u>GARDENVILLE MO</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>			
13a. FATHER'S NAME <u>CHARLES G. KIEHNE</u>			13b. MOTHER'S MAIDEN NAME <u>SOPHIA SCHLUE</u>			14. NAME OF HUSBAND OR WIFE <u>FRIEDA</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>481-14-9599</u>		17. INFORMANT <u>Mrs. R.C. Kiehne, Sikeston Mo</u>				Address		
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>Arteriosclerotic heart disease</u>							INTERVAL BETWEEN ONSET AND DEATH <u>?</u>			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Gen. arteriosclerosis</u>							?			
DUE TO (c)										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>chronic lymphatic leukemia</u>					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 _____ s.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>12-21-60</u> to <u>12-23-60</u> and last saw her <u>him</u> alive on <u>Dec 22, 1960</u> Death occurred at <u>7:50 AM</u> m on the date stated above, and to the best of my knowledge, from the causes stated.										
22a. SIGNATURE (Degree or title) <u>Wm. C. Critchlow MD</u>				22b. ADDRESS <u>Sikeston, MO</u>			22c. DATE SIGNED <u>Dec 28, 1960</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>12-26-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MEMORIAL PARK</u>			23d. LOCATION (City, town, or county) (State) <u>CAPE GIRARDEAU, MO</u>					
24. FUNERAL DIRECTOR <u>Welch Funeral Home - Sikeston Mo</u>				ADDRESS <u>Sikeston Mo</u>		25. DATE RECD. BY LOCAL REG. <u>1-4-1961</u>		26. REGISTRAR'S SIGNATURE <u>Maxella Hunter</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  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Raymond Crews

Licensed Embalmer No. 3467

P. O. Address Sikeston

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to do so 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.