

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS JAN 23 1961

-61-000886

Registration District No. 119 Primary Registration District No. 5443 Registrar's No. 2

STATE FILE NUMBER

AMENDED

DATE AMENDED
2

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

SHOULD READ

BY AFFIDAVIT OF

| | | | | | | | | | | | | | |
|---|--|---|--|--|--|--|---|---|---------------------------------|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>GASCONADE</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>GASCONADE</u> | | | | | | | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ROARK TWP</u> | | Length of stay in 1b <u>24RS</u> | | c. CITY OR TOWN <u>HERMANN</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>KRENEVALLEY HOME</u> | | | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) <u>217 W. 5th ST</u> | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | | | | | |
| 3. NAME OF DECEASED (Type or print) First <u>CLARA</u> Middle <u>KATTELMAN</u> Last <u>KATTELMAN</u> | | | | 4. DATE OF DEATH Month <u>JAN</u> Day <u>12</u> Year <u>1961</u> | | | | | | | | | |
| 5. SEX <u>FEMALE</u> | | 6. COLOR OR RACE <u>CAU.</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>12/27/1870</u> | | 9. AGE (last birthday) <u>90</u> | | IF UNDER 1 YEAR Months _____ Days _____ | | IF UNDER 24 HR Hours _____ Min. _____ | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u> | | 11. BIRTHPLACE (City and state or country) <u>HERMANN MO</u> | | 12. CITIZEN OF WHAT COUNTRY <u>U.S.</u> | | | | | |
| 13a. FATHER'S NAME <u>August Toedtman</u> | | | | 13b. MOTHER'S MAIDEN NAME <u>CATHERINE GOETZ</u> | | | | 14. NAME OF HUSBAND OR WIFE <u>ALBERT KATTELMANN</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>NONE</u> | | 17. INFORMANT Address <u>AMANDA PFOTENHAUER HERMANN MO</u> | | | | | | | |
| 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>Arteriosclerosis</u> | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs</u> | | | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ 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 checked="" 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. | | 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 <u>10-25-48</u> to <u>1-12-61</u> and last saw her/him alive on <u>1-3-61</u> Death occurred at <u>3:25 PM</u> on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | | | | | | | |
| 22a. SIGNATURE (Degree or title) <u>Carol T. Shaw M.D.</u> | | | | | | 22b. ADDRESS <u>Hermann, Mo.</u> | | | 22c. DATE SIGNED <u>1-13-61</u> | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | | 23b. DATE <u>1/16/61</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>MEMORIAL PARK</u> | | | 23d. LOCATION (City, town, or county) (State) <u>ST LOUIS CO., MO</u> | | | | | |
| 24. FUNERAL DIRECTOR ADDRESS <u>HUGO H. BLUMER HERMANN MO</u> | | | | | 25. DATE RECD. BY LOCAL REG. <u>1-14-61</u> | | 26. REGISTRAR'S SIGNATURE <u>Delmar Uffelman</u> | | | | | | |

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 *Gregory D. Deener*

Licensed Embalmer No. 3160

P. O. Address Herrmann Mo

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.