

COURT DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-002285

FILED VS FEB -2 1961

211

Registration District No. _____ Primary Registration District No. 4324 Registrar's No. 1-61

STATE FILE NUMBER

AMENDED

1. PLACE OF DEATH a. COUNTY <u>Miller</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Miller</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Tuscumbia</u>		Length of stay in 1b <u>1 month</u>	c. CITY OR TOWN <u>St. Elizabeth</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>Humphreys Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle _____ Last <u>Rehagen</u>			4. DATE OF DEATH Month <u>January</u> Day <u>19</u> Year <u>1961</u>		
---	--	--	---	--	--

5. SEX <u>Female</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>5-1-1893</u>	9. AGE (last birthday) <u>67</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>Housewife & School Cook</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>St. Elizabeth, Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>
---	-----------------------------------	---	--

13a. FATHER'S NAME <u>Herman Boeckman</u>	13b. MOTHER'S MAIDEN NAME <u>Thersa Alberts</u>	14. NAME OF HUSBAND OR WIFE <u>Frank Rehagen</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>	17. INFORMANT <u>Frank Rehagen</u>	Address <u>St. Elizabeth, 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>Coronary Thrombosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>30</u> Minutes
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) <u>Intertrochanteric Fracture Left Hip, Fracture arm</u>		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 checked="" 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.) <u>Fell on ice</u>
---	--	--

20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year <u>12-20-60</u>

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.) <u>Farm</u>	20f. CITY, TOWN, OR LOCATION <u>St. Elizabeth,</u>	COUNTY <u>Miller</u>	STATE <u>Mo.</u>
---	---	---	-------------------------	---------------------

21. I attended the deceased from <u>12-20-60</u> to <u>1-19-61</u> and last saw her/him alive on <u>1-19-61</u> Death occurred at <u>11:00 P.</u> on the date stated above, and to the best of my knowledge, from the causes stated.	
---	--

22a. SIGNATURE (Degree & title) <u>M.E. Humphrey D.O.</u>	22b. ADDRESS <u>Tuscumbia, Mo.</u>	22c. DATE SIGNED <u>1-23-61</u>
--	---------------------------------------	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>1-23-1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Lawrence Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>St. Elizabeth, Missouri</u>
--	-------------------------------	--	---

24. FUNERAL DIRECTOR <u>Humphrey Funeral Home Iberia, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>January 25, 1961</u>	26. REGISTRAR'S SIGNATURE <u>Geo. H. E. Kallenbach</u>
--	---	---

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

INSPECTION

SHOULD READ

ITEM NO.

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 J. G. Humphrey

Licensed Embalmer No. 4772

P. O. Address Springfield, 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.