

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-002315

FILED VS FEB 1 1961

AMENDED

Registration District No. 226 Primary Registration District No. 5801 Registrar's No. 5

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY Monroe				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Monroe			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Washington Twtnshp.		Length of stay in lb 14 Years		c. CITY OR TOWN R.F.D. Hunnewell.		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 3 Miles S.W. Hunnewell				Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 3 Miles, S.W. Hunnewell.	
3. NAME OF DECEASED (Type or print) First Ida Middle Elizabeth Last Mast.				4. DATE OF DEATH Month January Day 18, Year 1961			
5. SEX Female		6. COLOR OR RACE White		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 2/23/'68	
9. AGE (last birthday) 92		IF UNDER 1 YEAR Months 10 Days 25		IF UNDER 24 HR Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired housewife				10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (City and state or country) Liscomb, Iowa	
12. CITIZEN OF WHAT COUNTRY U.S.							
13a. FATHER'S NAME William Boyd				13b. MOTHER'S MAIDEN NAME Barbara Engle		14. NAME OF HUSBAND OR WIFE Josiah Mast. (deceased)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Adam Schleiermacher, Mo.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction. Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Coronary insufficiency. 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							INTERVAL BETWEEN ONSET AND DEATH 3 hours 3 weeks
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 March 1957 to Jan 16, 1961 and last saw her alive on Jan 17, 1961 Death occurred at 6:20 P m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) Chas A. Pichy MD				22b. ADDRESS Shelbina Mo.		22c. DATE SIGNED 1/23/61	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 1/22/1961		23c. NAME OF CEMETERY OR CREMATORIUM Fairview Cemetery		23d. LOCATION (City, town, or county) (State) Cedar Falls, Iowa.	
24. FUNERAL DIRECTOR Harold Garner, Monroe City, Mo.				25. DATE RECD. BY LOCAL REG. 1-24-61		26. REGISTRAR'S SIGNATURE Elsie Miller	

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

ITEM NO. SHOULD READ

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 Harvey S. Turner

Licensed Embalmer No. 3720

P. O. Address Monroe City

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.