

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

61-003835
STATE FILE NUMBER

318

1003

1124

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

AMENDED

FILED VS FFD 9 1961

DATE AMENDED

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>ILL.</u> b. COUNTY <u>MADISON</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST LOUIS</u>		Length of stay in lb <u>4 DAYS</u>	c. CITY OR TOWN <u>COLLINSVILLE</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ST. LUKES</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>RURAL ROUTE 1</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <u>GERTRUDE ELSIE WITTE</u>			4. DATE OF DEATH Month Day Year <u>FEBRUARY 2, 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>3/3/97</u>	9. AGE (last birthday) <u>63</u>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	11. BIRTHPLACE (City and state or country) <u>COLLINSVILLE, ILL.</u>	12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>	
13a. FATHER'S NAME <u>HENRY LINNEMAN</u>		13b. MOTHER'S MAIDEN NAME <u>IDA PROUGH</u>		14. NAME OF HUSBAND OR WIFE <u>BEN WITTE SR.</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>Ben Witte Jr.</u> Address <u>RR #1</u>		16. SOCIAL SECURITY NO.

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

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>Carcinoma of common bile duct</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) <u>1551</u>		INTERVAL BETWEEN ONSET AND DEATH <u>8 mo</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Diabetes mellitus</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 checked="" type="checkbox"/> NO <input 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>June 1955</u> to <u>Feb 2, 1961</u> and last saw her alive on <u>Feb 2, 1961</u> Death occurred at <u>10 AM</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>John L Horner M.D.</u>		22b. ADDRESS <u>114 N. TAYLOR, ST LOUIS (8)</u>	22c. DATE SIGNED <u>2-4-61</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	23b. DATE <u>2/5/61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>LUTHERAN CEMETERY</u>	23d. LOCATION (City, town, or county) (State) <u>COLLINSVILLE, ILLINOIS</u>
24. FUNERAL DIRECTOR <u>HERR FUNERAL HOME, COLLINSVILLE, ILL</u>		25. DATE RECD. BY LOCAL REG. <u>FEB 4 1961</u>	26. REGISTRAR'S SIGNATURE <u>[Signature] M.D.</u>

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 _____

W. H. H. H.

Licensed Embalmer No. 3577

P. O. Address Ballusville

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.