

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

77-61-004753

STATE FILE NUMBER

53

3010

77

AMENDED

Registration District No.

Primary Registration District No.

Registrar's No.

FILED VS FEB 27 1961

1. PLACE OF DEATH a. COUNTY <u>Cape Girardeau</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Cape Gir.</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Cape Girardeau</u>		c. CITY OR TOWN <u>Jackson</u>	
Length of stay in lb <u>1 day</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>Osteopathic Hosp.</u>		d. STREET ADDRESS (If outside, give location) <u>501 Neal</u>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Clarence Ervin Deimund</u>			4. DATE OF DEATH Month Day Year <u>February 18 1961</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>12/28/58</u>
9. AGE (last birthday) <u>2 yrs</u>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	11. BIRTHPLACE (City and state or country) <u>Jackson Mo</u>
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13a. FATHER'S NAME <u>Henry Deimund</u>	
13b. MOTHER'S MAIDEN NAME <u>Ida Barbee</u>		14. NAME OF HUSBAND OR WIFE <u>None</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 <u>Henry Deimund</u>		Address <u>501 Neal Jackson, 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>Cardiac Arrest</u>			INTERVAL BETWEEN ONSET AND DEATH <u>immediate</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Respiratory Failure</u>			<u>3-5 min</u>
DUE TO (c) <u>Bilateral Pneumonia</u>			<u>1 1/2 hours</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Loxix Nephrosis Loxix Diabetes mellitus</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 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>Dec 28/59</u> to <u>Feb 18/61</u> and last saw her/him alive on <u>Feb 18/61</u> Death occurred at <u>8:45 PM</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Walter W. Sutton D.D.</u> (Degree or title)		22b. ADDRESS <u>Jackson Mo.</u>	
22c. DATE SIGNED <u>2-21-61</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>Feb. 20, 1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Russell Heights</u>		23d. LOCATION (City, town, or county) (State) <u>Jackson, Mo.</u>	
24. FUNERAL DIRECTOR <u>W. C. Concept Jackson, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>2-23-61</u>	
26. REGISTRAR'S SIGNATURE <u>Gene Kasten</u>			

(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 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 H. C. Cunniff

Licensed Embalmer No. 4327

P. O. Address Lawson, Ill

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.