

SOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-006244

STATE FILE NUMBER

Registration District No. 216 Primary Registration District No. --- Registrar's No. 60

AMENDED FILED VS FEB 24 1961

DATE AMENDED 3/2/61
 INSTEAD OF disease
 ITEM NO. SHOULD READ
 18b Acute myocardial infarction Hypertensive cardiovascular
 18c Hypertensive cardiovascular disease Old arteriosclerosis
 18 Part II Cortical adenoma of kidney - Adeno carcinoma of prostate
 BY AFFIDAVIT OF Physician DOCUMENT

1. PLACE OF DEATH a. COUNTY <u>St Francois</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St Francois</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Francois Twp. Farmington -rural</u>			Length of stay in 1b		c. CITY OR TOWN <u>Farmington</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>Mineral Area Hospital</u>				Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>208 E 1st</u>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Henry</u> Last <u>Klob</u>				4. DATE OF DEATH Month <u>February</u> Day <u>14</u> Year <u>1961</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</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>3/23/1882</u>	
9. AGE (last birthday) <u>78</u>		IF UNDER 1 YEAR Months <u>---</u> Days <u>---</u>		IF UNDER 24 HR Hours <u>---</u> Min. <u>---</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>mechanic</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>retired</u>		11. BIRTHPLACE (City and state or country) <u>St Francois Co. Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>			
13a. FATHER'S NAME <u>August Klob</u>				13b. MOTHER'S MAIDEN NAME <u>Mary Kinneman</u>		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service.)				17. INFORMANT Address <u>Mrs William Pigg, Farmington, 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>ACUTE CIRCULATORY FAILURE</u> Acute Myocardial Infarction DUE TO (b) <u>HYPERTENSIVE CARDIOVASCULAR Disease Many yrs.</u> Hypertensive cardiovascular disease Many yrs. DUE TO (c) <u>OLD ARTERIOSCLEROSIS -</u> 9 da 3 wks.							INTERVAL BETWEEN ONSET AND DEATH <u>9 da</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>cortical adenoma of kidney - Adeno carcinoma of prostate</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 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 <u>---</u> a.m. <u>---</u> 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>1954</u> to <u>1961</u> and last saw him alive on <u>2-14-61</u> Death occurred at <u>3:10 pm</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>M. G. Goble MD</u> (degree or title)				22b. ADDRESS <u>Farmington Mo.</u>		22c. DATE SIGNED <u>2-14-61</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE <u>2/16/61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Lutheran Cemetery</u>		23d. LOCATION (City, town, or county) <u>Farmington, Mo</u>		(State)
24. FUNERAL DIRECTOR <u>Miller Funeral Home, Farmington, Mo</u> ADDRESS				25. DATE RECD. BY LOCAL REG. <u>Feb. 14, 1961</u>		26. REGISTRAR'S SIGNATURE <u>Cothran Rudloff</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 Paul K. Duesal

Licensed Embalmer No. 4129

P. O. Address Farmington, Me.

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.