

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-008164

Registration District No. 93

Primary Registration District No. _____

Registrar's No. 61-23

STATE FILE NUMBER

AMENDED

FILED MAR 20 1961

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

3. NAME OF DECEASED (Type or print) First Middle Last <u>Carl William Kollmeyer</u>			4. DATE OF DEATH Month Day Year <u>Mar 1 1961</u>		
---	--	--	---	--	--

5. SEX <u>Male</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>July 31 1874</u>	9. AGE (last birthday) <u>86</u>	IF UNDER 1 YEAR Months <u>7</u> Days <u>1</u>	IF UNDER 24 HR Hours <u>1</u> Min.
-----------------------	----------------------------------	---	---	-------------------------------------	--	---------------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	11. BIRTHPLACE (City and state or country) <u>Hoylston Ill</u>	12. CITIZEN OF WHAT COUNTRY <u>usa</u>
--	---	---	---

13a. FATHER'S NAME <u>August Kollmeyer</u>	13b. MOTHER'S MAIDEN NAME <u>Amelica Merht</u>	14. NAME OF HUSBAND OR WIFE <u>Dora Kollmeyer</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>Dora Kollmeyer Lockwood 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>Extreme congestive heart failure</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Arteriosclerotic heart disease</u>	<u>years</u>
	DUE TO (c) <u>Partial renal shut-down</u>	<u>2 days</u>

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 type="checkbox"/> No <input type="checkbox"/> Unknown
---	--

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 2-28-61 to 3-1-61 and last saw ^{her} alive on 3-1-61
Death occurred at 6:15 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Jerry J. Kinder, M.D.</u>	22b. ADDRESS <u>Lockwood, Mo.</u>	22c. DATE SIGNED <u>3-9-61</u>
--	--------------------------------------	-----------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Mar 4 1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Lockwood</u>	23d. LOCATION (City, town, or county) (State) <u>Lockwood Mo.</u>
--	--------------------------------	---	--

24. FUNERAL DIRECTOR <u>Allison Funeral Home Greenfield Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>3/13/1961</u>	26. REGISTRAR'S SIGNATURE <u>J. C. Canada</u>
--	--	--

(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED

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 W.R. Allison

Licensed Embalmer No. 4404
P. O. Address Greenville

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.