

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-008285

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 719 Primary Registration District No. 5443 Registrar's No. 12

STATE FILE NUMBER

AMENDED

FILED APR 5 1961

DATE AMENDED

INSTEAD OF THIS RECORD ARE AS FOLLOWS

SHOULD READ

DOCUMENT MEDICAL CERTIFICATION BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>GASCONADE</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>GASCONADE</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ROARK TWP</u>		Length of stay in 1b <u>77 YRS</u>	c. CITY OR TOWN <u>HERMANN</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>KRENE VALLEY NURSING HOME</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>S. MARKET ST</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>ROSA</u> Middle <u>ALVINE</u> Last <u>BIRKEL</u>			4. DATE OF DEATH Month <u>MARCH</u> Day <u>26</u> Year <u>1961</u>
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>CAU.</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>4/5/1883</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOME MAKER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOUSEHOLD</u>	9. AGE (last birthday) <u>77</u> IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HR: Hours _____ Min. _____
11. BIRTHPLACE (City and state or country) <u>HERMANN MO</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>	
13a. FATHER'S NAME <u>August Hesse</u>		13b. MOTHER'S MAIDEN NAME <u>Schmitt</u>	14. NAME OF HUSBAND OR WIFE <u>John Birkel</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>HA. BIRKEL</u> Address <u>HERMANN 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>ARTERIOLAR NEPHROSCLEROSIS</u>			INTERVAL BETWEEN ONSET AND DEATH <u>5 YRS.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ 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 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>1957</u> to <u>3-26-61</u> and last saw her/him alive on <u>3-25-61</u> Death occurred at <u>5</u> <u>P</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>George M. Workman MD</u>		22b. ADDRESS <u>HERMANN, MO</u>	22c. DATE SIGNED <u>3-27-61</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>3/29/1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>HERMANN CEMETERY</u>	23d. LOCATION (City, town, or county) (State) <u>HERMANN MO</u>
24. FUNERAL DIRECTOR <u>HERMAN Blum Inc</u>	ADDRESS <u>HERMANN MO</u>	25. DATE RECD. BY LOCAL REG. <u>3-27-61</u>	26. REGISTRAR'S SIGNATURE <u>Delma Uffelmann</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 *August B. Bennett*
Licensed Embalmer No. 3160

P. O. Address *Herrmann Pa*

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.