

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-010306

STATE FILE NUMBER

Registration District No. 314 Primary Registration District No. 4459 Registrar's No. 13

AMENDED

FILED MAR 23 1961

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
a. COUNTY <u>St Clair</u>		b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Osceola</u>		a. STATE <u>Mo</u>		b. COUNTY <u>St Clair</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Osceola</u>		Length of stay in lb		c. CITY OR TOWN <u>Osceola</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>Queen med</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>Part Home</u>			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH			
First <u>Thelma</u>		Middle <u>- Oehring</u>		Last <u>g</u>		Month Day Year <u>FEB 15-1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. Married <input type="checkbox"/> Widowed <input type="checkbox"/> Never Married <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>9/17/61</u>	9. AGE (last birthday) <u>43</u>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.	
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		11. BIRTHPLACE (City and state or country) <u>Joharville Mo</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>
13a. FATHER'S NAME <u>Walter Oehring</u>			13b. MOTHER'S MAIDEN NAME <u>unknown</u>			14. NAME OF HUSBAND OR WIFE	
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 Address <u>Part Home - Osceola Mo</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:							INTERVAL BETWEEN ONSET AND DEATH <u>10 min</u>
IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u>							
DUE TO (b) <u>mitral insufficiency and</u>							
DUE TO (c) <u>decompensation</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>years of mental insecurity care institutional</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 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 <u>1-1954</u> to <u>2-15-61</u> and last saw her alive on <u>2-15-61</u> Death occurred at <u>5:30 P</u> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>Ruth Severs MD</u>				22b. ADDRESS <u>Osceola Mo</u>			22c. DATE SIGNED <u>3-15-61</u>
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <u>2-17-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Joharville</u>		23d. LOCATION (City, town, or county) (State) <u>Joharville Mo</u>		
24. FUNERAL DIRECTOR <u>Benjamin Home, Osceola Mo</u>			25. DATE RECD. BY LOCAL REG. <u>3-15-61</u>		26. REGISTRAR'S SIGNATURE <u>Ruth Severs</u>		

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

SHOULD READ

BY AFFIDAVIT OF

ITEM NO.

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 J B Goodrich

Licensed Embalmer No. 3038

P. O. Address Osceola Mo

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.