

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-014278

STATE FILE NUMBER

Registration District No. 169 Primary Registration District No. \_\_\_\_\_ Registrar's No. 16

AMENDED

**FILED MAY 1 1961**

1. PLACE OF DEATH a. COUNTY <u>KNOX</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO.</u> b. COUNTY <u>KNOX</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>BARING</u>		Length of stay in 1b <u>MOST OF LIFE</u>	c. CITY OR TOWN <u>BARING</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		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>EMANUAL L. KURTZ</u>			4. DATE OF DEATH Month Day Year <u>APRIL 18-1961</u>
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</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>12-14-1899</u>
9. AGE (last birthday) <u>81</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>FARMER LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	11. BIRTHPLACE (City and state or country) <u>KNOX COUNTY</u>
12. CITIZEN OF WHAT COUNTRY		13a. FATHER'S NAME <u>JOHN KURTZ</u>	
13b. MOTHER'S MAIDEN NAME <u>LINDA LOREY</u>		14. NAME OF HUSBAND OR WIFE <u>LULA TUCKER KURTZ</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>NO</u>	17. INFORMANT Address <u>Mrs. LULA KURTZ BARING, 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>Arteriosclerotic heart disease grade III</u> INTERVAL BETWEEN ONSET AND DEATH <u>15 yrs.</u> DUE TO (b) <u>Generalized arteriosclerosis</u> <u>20 yrs.</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			
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 <u>Jan 18<sup>th</sup> 1956</u> to <u>Apr. 18<sup>th</sup> 1961</u> and last saw <sup>her</sup> him alive on <u>Feb 21<sup>st</sup> 1961</u> Death occurred at <u>4:30 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Francis Tarvydas M.D.</u>		22b. ADDRESS <u>Eolina Missouri</u>	22c. DATE SIGNED <u>Apr. 21<sup>st</sup> 1961</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>4-21-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>ST. ALOYSIUS</u>	23d. LOCATION (City, town, or county) <u>BARING, MO.</u>
24. FUNERAL DIRECTOR ADDRESS <u>KRIEGSHAUSER Bros</u>		25. DATE RECD. BY LOCAL REG. <u>April 24-1961</u>	26. REGISTRAR'S SIGNATURE <u>Will A. Plummer</u>

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

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 Paul C. Kriegshauser

Licensed Embalmer No. 4085

P. O. Address Edina 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.