

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-016882

STATE FILE NUMBER

Registration District No. 77 Primary Registration District No. 3016 Registrar's No. 161

AMENDED

FILED MAY 29 1961

1. PLACE OF DEATH a. COUNTY <u>COLE</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>COLE</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>JEFFERSON CITY, MO.</u>		c. CITY OR TOWN <u>JEFFERSON CITY, MO.</u>	
Length of stay in 1b		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>ST MARYS HOSPITAL</u>		d. STREET ADDRESS (If outside, give location) <u>306 E MILLER</u>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>HENRY</u> Middle <u>BOCK</u> Last	4. DATE OF DEATH Month <u>5</u> Day <u>20</u> Year <u>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>2/3/92</u>	9. AGE (last birthday) <u>69</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>RETIRED HIGHWAY EMPLOYEE</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>WARDSVILLE, MO.</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
--	-----------------------------------	--	---

13a. FATHER'S NAME <u>JOSEPH BOCK</u>	13b. MOTHER'S MAIDEN NAME <u>CATHERINE TWEHOUS</u>	14. NAME OF HUSBAND OR WIFE <u>LINNIE AMOS</u>
--	---	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>YES WAR I</u>	16. SOCIAL SECURITY NO.	17. INFORMANT <u>MRS LINNIE BOCK</u>	Address <u>J C 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>Lymphatic Leukemia</u> <u>also</u> (b) <u>Pneumonia Rt. Lung</u> <u>also</u> (c) <u>arterio-sclerotic heart disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>(?)</u> <u>days</u> <u>years</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 checked="" 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 May 19-61 to May 20-61 and last saw her/him alive on May 20-61  
 Death occurred at 10:45 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Francis X. Meier M.D.</u>	(Degree or title)	22b. ADDRESS <u>Jeff. City, Mo.</u>	22c. DATE SIGNED <u>5/20/61</u>
--	-------------------	--	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>5/22/61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Resurrection</u>	23d. LOCATION (City, town, or county) (State) <u>Jefferson City, Mo.</u>
--	-----------------------------	---	---

24. FUNERAL DIRECTOR <u>Lyvester Dulle</u>	ADDRESS <u>J C MO.</u>	25. DATE RECD. BY LOCAL REG. <u>25 May 1961</u>	26. REGISTRAR'S SIGNATURE <u>R.P. Harris M.D. Richter D.D.</u>
---	---------------------------	--	---

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

NEW NO.

MAY 29 1961

VS JUN 2 1961

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 \_\_\_\_\_

Licensed Embalmer No. 4321

P. O. Address \_\_\_\_\_

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.