

SOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-017035

STATE FILE NUMBER

Registration District No. 118 Primary Registration District No. 4190 Registrar's No. 19

AMENDED

FILED MAY 22 1961

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>Blanc</u>		Length of stay in 1b <u>15 yrs</u>	c. CITY OR TOWN <u>Blanc</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>AT home</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>Blanc</u>
			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Adele</u> Middle <u>L.</u> Last <u>Brown</u>			4. DATE OF DEATH Month <u>MAY</u> Day <u>10</u> Year <u>1961</u>	
--	--	--	---	--

5. SEX <u>Female</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>Aug 1 - 1897</u>	9. AGE (last birthday) <u>63</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	IF UNDER 24 HR Hours <u>0</u> Min. <u>0</u>
----------------------	-------------------------------	---	--------------------------------------	----------------------------------	---	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>house wife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	11. BIRTHPLACE (City and state or country) <u>St. Louis - MO</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
---	--	--	---

13a. FATHER'S NAME <u>Gottlieb Steighorst</u>	13b. MOTHER'S MAIDEN NAME <u>Caroline Rinne</u>	14. NAME OF HUSBAND OR WIFE <u>deceased</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>—</u>	17. INFORMANT Address <u>Mrs Alvie Winsel - Blanc - 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
IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>CARDIAC ANNOXIA</u>	<u>5 days</u>
	DUE TO (c) <u>CARDIAC DECOMPENSATION</u>	<u>3 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>CORONARY INSUFFICIENCY</u>		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 <u>—</u> a.m. <u>—</u> p.m. <u>—</u>	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 Sept 1956 to May 1961 and last saw her alive on May 9, 1961
Death occurred at 5:30 A.m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Wm Fedler</u> (Degree or title)	22b. ADDRESS <u>Blanc, MO</u>	22c. DATE SIGNED <u>5/12/61</u>
---	-------------------------------	---------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>May 13 - 1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Old Blanc Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Blanc - MO</u>
---	--------------------------------	--	---

24. FUNERAL DIRECTOR ADDRESS <u>Charles James Funeral Service</u> <u>Blanc - MO</u>	25. DATE RECD. BY LOCAL REG. <u>May 13, 1961</u>	26. REGISTRAR'S SIGNATURE <u>Mrs. Maurine Jappmyer</u>
--	--	--

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

AUG 2 1961

JUN 16 1961

JUL 13 1962

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 Chester Lassman

Licensed Embalmer No. 4178

P. O. Address Blond-1

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.