SSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

-61-021967
STATE FILE NUMBER

AMENDED

Registration District No. 231 Primary Registration District No. 5808 Registrar's No. 36

FILED JUL 12 1961

DATE AMENDED | INSTEAD OF | SHOULD READ | ITEM NO. | DOCUMENT | BY AFFIDAVIT OF

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: High Hill
Length of stay in 1b
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION
Inside Limits Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MO b. COUNTY: MONTGOMERY
c. CITY OR TOWN: High Hill
Inside Limits Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location)
Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First: ANNE Middle: E Last: STREIF
4. DATE OF DEATH Month: 7 Day: 2 Year: 61
5. SEX: Female
6. COLOR OR RACE: White
7. Married ☐ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 7-18-68
9. AGE (last birthday): 92
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): Worker post office
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and state or country): High Hill Mo
12. CITIZEN OF WHAT COUNTRY
13a. FATHER'S NAME: Jacob Streif
13b. MOTHER'S MAIDEN NAME: Anna Steinegger
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)
16. SOCIAL SECURITY NO.: —
17. INFORMANT: J. B. Holtman Address: Mexico Mo

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Dilitation Rt. Ventricle of Heart — INTERVAL BETWEEN ONSET AND DEATH: Sudden
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Chronic Myocarditis — 10 yrs.
DUE TO (c) Arteria - Sclerosis — 10 yrs.
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. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
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 March 10.1957, to July 3.1961 and last saw her/him alive on June 28.1961
Death occurred at July 2-1961 m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: James O. Helm (Degree or title) M.D.
22b. ADDRESS: New Florence Mo
22c. DATE SIGNED: 7-4-61

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 7-4-61
23c. NAME OF CEMETERY OR CREMATORY: Mount Pleasant
23d. LOCATION (City, town, or county): High Hill (State): Mo

24. FUNERAL DIRECTOR: C. A. Harding ADDRESS: Jonesburg Mo.
25. DATE RECD. BY LOCAL REG.: 7-4-1961
26. REGISTRAR'S SIGNATURE: Laura B. Calloway

(Licensed Embalmer's Statement on Reverse Side)

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_____ Signed Carl A. Harding
Signature of Student Embalmer

Licensed Embalmer No. 4115

P. O. Address Jonesburg

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.