

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 719 Primary Registration District No. 5993 Registrar's No. 35 **-61-024706**
STATE FILE NUMBER

AMENDED

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

| | | | | | | | | | | | | | |
|---|--|---|--|---|--|--|---|---|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Gasconade | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Mo b. COUNTY Gasconade | | | | | | | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Roark Township | | Length of stay in 1b 1 1/2 Months | | c. CITY OR TOWN Hermann | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | | | | | | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Krene Valley N. Home | | | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) 5th & Market Sts | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | | | | | |
| 3. NAME OF DECEASED (Type or print) First ELIZABETH Middle FLUETSCH Last FLUETSCH | | | | 4. DATE OF DEATH Month July Day 12 Year 1961 | | | | | | | | | |
| 5. SEX Female | | 6. COLOR OR RACE Cau. | | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | | 8. DATE OF BIRTH 10/27/1869 | | 9. AGE (last birthday) 91 | | IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> | | IF UNDER 24 HR Hours <input type="checkbox"/> Min. <input type="checkbox"/> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper | | | | 10b. KIND OF BUSINESS OR INDUSTRY Household | | 11. BIRTHPLACE (City and state or country) Swiss, Mo | | 12. CITIZEN OF WHAT COUNTRY US | | | | | |
| 13a. FATHER'S NAME Jacob Moeckli | | | | 13b. MOTHER'S MAIDEN NAME Cedonia Allemann | | | | 14. NAME OF HUSBAND OR WIFE Andrew Fluetsch | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT Herman J. Fluetsch, Hermann, Mo Address | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of rectum | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 6 mo | | | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ | | | | | | | | | | | | | |
| 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 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 11-8-50 to 7-12-61 and last saw her/him alive on 7-10-61 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 (Degree or title) Carol T. Shaw, MD | | | | 22b. ADDRESS Hermann, Mo. | | | | 22c. DATE SIGNED 7-12-61 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 7/14/61 | | 23c. NAME OF CEMETERY OR CREMATORY St. John Cemetery | | 23d. LOCATION (City, town, or county) Swiss Mo | | | | | | | |
| 24. FUNERAL DIRECTOR ADDRESS Herman Blumer Inc Hermann, Mo | | | | 25. DATE RECD. BY LOCAL REG. 7-13-61 | | 26. REGISTRAR'S SIGNATURE Delma Uffelman | | | | | | | |

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 ORVAL GRONER, Student Embalmer No. 641

working under my personal supervision.

Student Orval Groner
Signature of Student Embalmer

Signed August Gruener
Licensed Embalmer No. 3160

P. O. Address Hermann, 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.