

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-61-025837
STATE FILE NUMBER

AMENDED

Registration District No. 174 Primary Registration District No. 3035 Registrar's No. _____

FILED AUG 9 1961

1. PLACE OF DEATH a. COUNTY <u>D Lafayette</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>D Lafayette</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Lexington</u>		Length of stay in 1b <u>3 weeks</u>	c. CITY OR TOWN <u>Higginsville</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF HOSPITAL OR INSTITUTION <u>Memorial Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>2705 Walnut</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>Christian</u> Last <u>Roman</u>			4. DATE OF DEATH Month <u>July</u> Day <u>12</u> Year <u>1961</u>		
5. SEX <u>m</u>	6. COLOR OR RACE <u>w</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>9/8/1880</u>	9. AGE (last birthday) <u>80</u>	IF UNDER 1 YEAR Months _____ Days _____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm Owner</u>		11. BIRTHPLACE (City and state or country) <u>Kansas City, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Pelix Roman</u>			13b. MOTHER'S MAIDEN NAME <u>Augusta Meyer</u>			14. NAME OF HUSBAND OR WIFE <u>Minnie Carrie Thomas</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. _____		17. INFORMANT <u>Albert Roman - Higginsville, Mo.</u> 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) <u>Uremia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs.</u>
DUE TO (b) <u>Chronic Glomerulonephritis</u> <u>aggravated by injury received in auto accident</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Fracture of ribs - posteriorly</u> <u>Fracture of left patella</u> <u>Fracture of right femur</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 checked="" 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.) <u>Auto accident 6-19-61</u>	
20c. TIME OF INJURY Hour <u>5:30 p.m.</u> Month, Day, Year <u>6-19-61</u>	20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>4 miles N. of Higginsville</u>		

21. I attended the deceased from June 19 - 1961 to July 12 - 1961 and last saw him alive on _____
Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>J.P. Koppens, M.D.</u>		22b. ADDRESS <u>Higginsville, Mo.</u>		22c. DATE SIGNED <u>July 30-61</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>July 14, 1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Latona</u>	23d. LOCATION (City, town, or county) (State) <u>Higginsville, Mo.</u>		
24. FUNERAL DIRECTOR <u>Wiegert-Ottelhof, Higginsville, Mo.</u>			25. DATE RECD. BY LOCAL REG. <u>8/1/61</u>		26. REGISTRAR'S SIGNATURE <u>Harold W. W. M.D.</u>

(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED
 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 SHOULD READ
 BY AFFIDAVIT OF

AUG 10 1961

VS AUG 9 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 *Robert Richhof*

Licensed Embalmer No. 4784

P. O. Address Highsville, 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.