

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-030294
STATE FILE NUMBER

AMENDED

Registration District No. 275 Primary Registration District No. 3053 Registrar's No. 183
FILED AUG 31 1961

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|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1. PLACE OF DEATH a. COUNTY <u>Phelps</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Maries</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Rolla Mo</u> | | c. CITY OR TOWN <u>Belle</u> | |
| c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>McFarland Nursing Home</u> | | d. STREET ADDRESS (If outside, give location) <u>NONE</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>HENRY</u> Middle <u>FLEISCHMANN</u> Last <u>FLEISCHMANN</u> | | 4. DATE OF DEATH Month <u>Aug</u> Day <u>19</u> Year <u>1961</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>1/22/83</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u> | 11. BIRTHPLACE (City and state or country) <u>Maries County, Mo.</u> |
| 13. FATHER'S NAME <u>John Fleischmann</u> | | 13b. MOTHER'S MAIDEN NAME <u>Barbra Weller</u> | 14. NAME OF HUSBAND OR WIFE <u>None</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>None</u> | 17. INFORMANT <u>Mrs. B. J. Jones, Belle 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>cerebral hemorrhage</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | | INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a). <u>arteriosclerosis</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 _____ 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 <u>2-22-61</u> to <u>8-19-61</u> and last saw him alive on <u>8-17-61</u> 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>E. E. Ferid, M.D.</u> | | 22b. ADDRESS <u>Rolla Mo</u> | 22c. DATE SIGNED <u>8-23-61</u> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE <u>Aug 22</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Koenig</u> | 23d. LOCATION (City, town, or county) (State) <u>Oregon County Mo</u> |
| 24. FUNERAL DIRECTOR <u>Edward Jones Belle Mo</u> | | 25. DATE RECD. BY LOCAL REG. <u>Aug 22, 1961</u> | 26. REGISTRAR'S SIGNATURE <u>Nadene L Stoll</u> |

DATE AMENDED
AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
INSTEAD OF
BY AFFIDAVIT OF
ITEM NO. SHOULD READ

DOCUMENT
MEDICAL CERTIFICATION

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 *Anna Howard Jones*

Licensed Embalmer No. *4411*

P. O. Address *Belle Me*

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.