

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-036388

STATE FILE NUMBER

Registration District No. 87 Primary Registration District No. 4150 Registrar's No. 12

AMENDED

FILED OCT 16 1961

| | | | |
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| 1. PLACE OF DEATH a. COUNTY <u>CRAWFORD</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>CRAWFORD</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>BOURBON</u> | | c. CITY OR TOWN <u>BOURBON</u> | |
| Length of stay in 1b <u>61KRS</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>AT HOME</u> | | d. STREET ADDRESS (If outside, give location) <u>NONE</u> | |
| Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>JOHN (NMI) MERKEL</u> | | | 4. DATE OF DEATH Month Day Year <u>OCT 6 1961</u> |
| 5. SEX <u>MALE</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>2-15-1870</u> |
| 9. AGE (last birthday) <u>91</u> | | 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) <u>FREEMILL PROPRIETOR</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>RETIRED</u> | 11. BIRTHPLACE (City and state or country) <u>JEFFRIESBURG MO</u> |
| 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> | | 13a. FATHER'S NAME <u>MIKE MERKEL</u> | |
| 13b. MOTHER'S MAIDEN NAME <u>UNKNOWN</u> | | 14. NAME OF HUSBAND OR WIFE <u>PORTHEA HERTLEIN</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>NIL</u> | 17. INFORMANT Address <u>FRED MERKEL BOURBON 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>HEART FAILURE</u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>MINUTES</u> |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>CONGESTIVE FAILURE PNETOLUNG METASTASIS</u> | | | <u>1 WK</u> |
| DUE TO (c) <u>CA OF BLADDER</u> | | | <u>3-4 Mo+</u> |
| 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 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>4 OCT 61</u> to <u>6 OCT 61</u> and last saw ^{her} him alive on <u>5 OCT 61</u> | | | |
| Death occurred at <u>7⁰² AM</u> on the date stated above, and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE <u>Robert N. Sapp</u> | | 22b. ADDRESS <u>BOURBON MO</u> | 22c. DATE SIGNED <u>8 OCT 61</u> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City, town, or county) (State) |
| <u>BURIAL</u> | <u>10-8-61</u> | <u>BOURBON</u> | <u>BOURBON MO</u> |
| 24. FUNERAL DIRECTOR | ADDRESS | 25. DATE RECD. BY LOCAL REG. | 26. REGISTRAR'S SIGNATURE |
| <u>NORMAN C HOENER</u> | <u>CUPA MO</u> | <u>OCT 8, 1961</u> | <u>[Signature]</u> |

(Licensed Embalmer's Statement on Reverse Side)

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

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 Norman C. Hoener

Licensed Embalmer No. 4673

P. O. Address Cuba 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.