

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-036483

AMENDED

Registration District No. 116 Primary Registration District No. 3020 Registrar's No. 238 STATE FILE NUMBER

**FILED OCT 23 1961**

1. PLACE OF DEATH a. COUNTY <b>Franklin</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) Mo. STATE Mo. b. COUNTY <b>Montgomery</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Washington</b>		Length of stay in 1b <b>1 day</b>	c. CITY OR TOWN <b>Mc Kittrick</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Francis Hospital</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>3 Miles South of Big Spring</b>		
3. NAME OF DECEASED (Type or print) First Middle Last <b>Anna Koewing</b>			4. DATE OF DEATH Month Day Year <b>Oct. 15 1961</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>12-22-1875</b>	9. AGE (last birthday) <b>85</b> IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>house work</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>St. Charles, Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.</b>	
13a. FATHER'S NAME <b>August Koewing</b>		13b. MOTHER'S MAIDEN NAME <b>Elizabeth Kemper</b>		14. NAME OF HUSBAND OR WIFE <b>None</b>		
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. <b>None</b>	17. INFORMANT Address <b>Mrs. Louis Bauer Mc Kittrick Mo.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ARTERIOSCLEROTIC GANGRENE LET + LEG</b>					INTERVAL BETWEEN ONSET AND DEATH <b>1 wk</b>	
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 type="checkbox"/> No <input type="checkbox"/> Unknown		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input 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
20f. CITY, TOWN, OR LOCATION		COUNTY		STATE		
21. I attended the deceased from <u>1947</u> to <u>10-15-61</u> and last saw her/him alive on <u>10-15-61</u> Death occurred at <u>12:45 P.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE (Degree or title) <b>George M. Workman M.D.</b>				22b. ADDRESS <b>HERMANN, Mo</b>		22c. DATE SIGNED <b>10-16-61</b>
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county)		(State)
<b>Burial</b>	<b>Oct. 18 1961</b>	<b>Big Spring Methodist</b>		<b>Big Spring</b>		<b>Mo.</b>
24. FUNERAL DIRECTOR ADDRESS <b>D.B. Baker New Florence Mo.</b>			25. DATE RECD. BY LOCAL REG. <b>10/18/61</b>		26. REGISTRAR'S SIGNATURE <i>Lula P. Hickman</i>	

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1961 OCT 26 100

**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 D B Baker

Licensed Embalmer No. 3375

P.O. Address New Florence 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.