

MOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=61-040022

STATE FILE NUMBER

Registration District No. 10 Primary Registration District No. 5033 Registrar's No. 268

FILED DEC 13 1961

1. PLACE OF DEATH a. COUNTY <u>Audrain</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Audrain</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Loutre Twp.</u>		c. CITY OR TOWN <u>Loutre Twp</u>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>RR#2 MARTINSBURG</u>		d. STREET ADDRESS (If outside, give location) <u>RR#2 MARTINSBURG</u>	

3. NAME OF DECEASED (Type or print) First Middle Last <u>FRANK</u> <u>JOHN</u> <u>ARENS</u>			4. DATE OF DEATH Month Day Year <u>Dec. 6 - 1961</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐	8. DATE OF BIRTH <u>1/31/1883</u>	9. AGE (last birthday) <u>78</u>	IF UNDER 1 YEAR Months <u>10</u> Days <u>25</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>GEN FARMING</u>		11. BIRTHPLACE (City and state or country) <u>ST Charles Co Mo</u>	
12. CITIZEN OF WHAT COUNTRY <u>U.S.A</u>		13a. FATHER'S NAME <u>Theodore Arens</u>		13b. MOTHER'S MAIDEN NAME <u>Christina WATTS</u>	
14. NAME OF HUSBAND OR WIFE <u>Josephine Fischer</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>489-42-8871</u>	
17. INFORMANT <u>Mrs Josp. ARENS - Martinsburg 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>Comp. Myocardial Infarction</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>10 min.</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. ☐ Yes ☐ No ☐ Unknown		
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19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒	20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐	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 ☐ NOT WHILE AT WORK ☐	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 12-6-61 to 12-6-61 and last saw him alive on 12-6-61
Death occurred at 12-6-61 - 9 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Willis H. Waller</u>	(Degree or title)	22b. ADDRESS <u>Wellsville Mo.</u>	22c. DATE SIGNED <u>12/6/61</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>	23b. DATE <u>12/9/61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>ST Joseph</u>	23d. LOCATION (City, town, or county) State <u>MARTINSBURG Mo</u>

24. FUNERAL DIRECTOR <u>HOWARD F MYERS</u>	ADDRESS <u>Wellsville Mo</u>	25. DATE RECD. BY LOCAL REG. <u>Dec. 8 - 1961</u>	26. REGISTRAR'S SIGNATURE <u>Blanche Neely</u>
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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 Howard F. Myers

Licensed Embalmer No. 4494

P. O. Address Wellsville N.Y.

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.