

OURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-041568

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

AMENDED

Registration District No. 172 Primary Registration District No. 3034 Registrar's No. 82

STATE FILE NUMBER

FILED NOV 29 1961

1. PLACE OF DEATH a. COUNTY <u>Lafayette</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Higginsville</u> Length of stay in 1b <u>2 days</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Iowa</u> b. COUNTY _____ c. CITY OR TOWN <u>Counsel Bluffs</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>Huntington Ave</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>208 W. 22nd St.</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>Huntington Ave</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>Walter</u> Middle <u>Martin</u> Last <u>Arfmann</u>			4. DATE OF DEATH Month <u>Nov.</u> Day <u>23</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	9. AGE (last birthday) <u>67</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>R.P. Employee</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Chicago Heights, Ill.</u>		11. BIRTHPLACE (City and state or country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY

13a. FATHER'S NAME <u>John Martin Arfmann</u>		13b. MOTHER'S MAIDEN NAME <u>Wilhelmina Ratterman</u>		14. NAME OF HUSBAND OR WIFE <u>Stella Arfmann</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>Yes W.W.I.</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>George Arfmann - 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>Acute Pulmonary Edema</u> DUE TO (b) <u>Chronic Constrictive Heart Failure</u> DUE TO (c) <u>H.P.U. Disease</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs.</u> <u>Yrs.</u> <u>Yrs.</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 11-23-61 to 11-23-61 and last saw him alive on 11-23-61
 Death occurred at 5:25 P m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Robert S. Best, M.D.</u>		22b. ADDRESS <u>Higginsville, Mo.</u>		22c. DATE SIGNED <u>11/24/61</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removed</u>		23b. DATE <u>Nov. 24, 61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>City Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Zutax, Nebraska</u>
24. FUNERAL DIRECTOR <u>Wieggers-Rickhof, Higginsville, Mo.</u> ADDRESS _____			25. DATE RECD. BY LOCAL REG. <u>Nov. 27-1961</u>		26. REGISTRAR'S SIGNATURE <u>Lutie Gordon Jordan</u>

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

DEC 5 1961

DEC 12 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 *Frank A. Rickhof*
Licensed Embalmer No. 4284

P. O. Address. *Higginsville,*

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.