

SOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

368 - 81-041940
STATE FILE NUMBER

AMENDED

Registration District No. 274 Primary Registration District No. 305V Registrar's No. _____

FILED DEC 11 1961

| | | | | | | | |
|--|--|---|---|---|--|--|--|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) | | | |
| a. COUNTY Pettis | | b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Sedalia | | Length of stay in 1b | | a. STATE Missouri b. COUNTY 2053 | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Bothwell Hospital | | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | | c. CITY OR TOWN Concordia | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| | | | | d. STREET ADDRESS none | | Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) | | | | 4. DATE OF DEATH | | 5. AGE (last birthday) | |
| First MARY | | Middle A. | | Last MEYER | | Month Day Year Nov. 28, 1961 | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | | 8. DATE OF BIRTH 12/3/77 | |
| 9. AGE (last birthday) 83 | | 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) Housewife | | | 10b. KIND OF BUSINESS OR INDUSTRY Own Home | | 11. BIRTHPLACE (City and state or country) Germany | | 12. CITIZEN OF WHAT COUNTRY U.S.A. |
| 13a. FATHER'S NAME Casper Breder | | | 13b. MOTHER'S MAIDEN NAME Anna Huelemann | | | 14. NAME OF HUSBAND OR WIFE Frank G. Meyer | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO | | | 16. SOCIAL SECURITY NO. ***** | | 17. INFORMANT Albert H. Meyer, Concordia, Mo. | | Address |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> | | | | | | | <u>12 Days</u> |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | | | | | | |
| DUE TO (b) <u>Cerebral Arteriosclerosis</u> | | | | | | | |
| 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 checked="" 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>9/4/61</u> to <u>11/28/61</u> and last saw her/him alive on <u>11/27/61</u> . Death occurred at <u>7:30 P.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | |
| 22a. SIGNATURE <u>H. G. Kappa D.O.</u> (Degree or title) | | | | 22b. ADDRESS <u>Stover, Mo</u> | | 22c. DATE SIGNED <u>12/30/61</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 11/30/61 | | 23c. NAME OF CEMETERY OR CREMATORY St. Paul's Lutheran Cemetery | | 23d. LOCATION (City, town, or county) (State) Concordia, Mo. | |
| 24. FUNERAL DIRECTOR James Funeral Home, Concordia, Mo. ADDRESS | | | | 25. DATE RECD. BY LOCAL REG. 12-5-1961 | | 26. REGISTRAR'S SIGNATURE <u>Frances Shelby</u> | |

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

ITEM NO. SHOULD READ

BY AFFIDAVIT OF

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 R. E. Baker

Licensed Embalmer No. 2419
P. O. Address Seaside

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.