

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-045814

STATE FILE NUMBER

AMENDED

Registration District No. 275 Primary Registration District No. 3053 Registrar's No. 258  
 FILED DEC 21 1961

1. PLACE OF DEATH a. COUNTY <u>Phelps</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>OSAGE</u>											
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Bella</u>		Length of stay in lb <u>1 year</u>		c. CITY OR TOWN <u>Belle</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>									
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>McMORLAND NURSING HOME</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>NORTH OF BELLE</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>								
3. NAME OF DECEASED (Type or print) First Middle Last <u>GEORGE FLEISCHMANN</u>				4. DATE OF DEATH Month Day Year <u>Dec 8 1961</u>											
5. SEX <u>m</u>		6. COLOR OR RACE <u>white</u>		7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>11/19/76</u>		9. AGE (last birthday) <u>85</u>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HR Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <u>FARMER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>FARMER</u>				11. BIRTHPLACE (City and state or country) <u>Marion Co. Mo</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>					
13a. FATHER'S NAME <u>John Fleischmann</u>				13b. MOTHER'S MAIDEN NAME <u>BARBARA WELER</u>				14. NAME OF HUSBAND OR WIFE <u>NONE</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>NONE</u>				17. INFORMANT <u>Mrs B. J. Jones Belle 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>Carcinoma of prostate</u>										INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u>					
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 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>Dec 1, 1961</u> to <u>Dec 8, 1961</u> and last saw him alive on <u>Dec 8, 1961</u> Death occurred at <u>11:00 pm</u> on the date stated above, and to the best of my knowledge, from the causes stated.															
22a. SIGNATURE (Degree or title) <u>Dr. Andrew D. ...</u>						22b. ADDRESS <u>Bella Mo</u>				22c. DATE SIGNED <u>12/12/61</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>12/10/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Keenig Cemetery</u>				23d. LOCATION (City, town, or county) (State) <u>North of Belle Mo</u>							
24. FUNERAL DIRECTOR <u>Edward Jones Belle Mo</u>				ADDRESS		25. DATE RECD. BY LOCAL REG. <u>Dec. 12, 1961</u>		26. REGISTRAR'S SIGNATURE <u>Nadene L. Stoll</u>							

(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

**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 Omer F. Lawrence Jones

Licensed Embalmer No. 4411

P. O. Address Belle me

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.