

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-005791

Registration District No. 53 Primary Registration District No. 3010 Registrar's No. 120 STATE FILE NUMBER

AMENDED

FILED MAR 13 1962

1. PLACE OF DEATH a. COUNTY <u>CAPE GIRARDEAU</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>SCOTT</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>CAPE GIRARDEAU</u>		c. CITY OR TOWN <u>ORAN</u>	
Length of stay in lb <u>2 days</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ST. FRANCIS HOSPITAL</u>		d. STREET ADDRESS (If outside, give location)	
Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>AGNES</u> Middle <u>M. DANNENMUELLER</u> Last <u></u>			4. DATE OF DEATH Month <u>MARCH</u> Day <u>4</u> Year <u>1962</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>10/21/91</u>	9. AGE (last birthday) <u>70</u>	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) <u>HOUSE KEEPER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>IN OWN HOME</u>		11. BIRTHPLACE (City and state or country) <u>NEW HAMBURG, MO.</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>
13a. FATHER'S NAME <u>NICHOLAS DANNENMUELLER</u>		13b. MOTHER'S MAIDEN NAME <u>MAY STIKES</u>		14. NAME OF HUSBAND OR WIFE <u>MRS. LEO HAMM ORAN, MO.</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. LEO HAMM ORAN, 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>Congestive heart failure</u>			INTERVAL BETWEEN ONSET AND DEATH <u>approx. 2 weeks.</u> <u>unk.</u>
DUE TO (b) <u>arteriosclerotic heart disease</u>			
DUE TO (c) <u>and cor pulmonale</u> <u>Severe cystic pulmonary emphysema unk.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Bronchopneumonia</u>			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 checked="" 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	STATE
21. I attended the deceased from <u>3-2-62</u> to <u>death</u> and last saw her/him alive on <u>March 3, 1962</u> Death occurred at <u>4:00a</u> m on the date stated above, and to the best of my knowledge, from the causes stated.				

22. SIGNATURE (Degree or title) <u>Jean A. Chopman, M.D.</u>		22b. ADDRESS <u>1902 Broadway, Cape Girardeau, Mo.</u>		22c. DATE SIGNED <u>6 March 62</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>MARCH 6 1962</u>	23c. NAME OF CEMETERY OR CREMATOR <u>NEW GUARDIAN</u>		23d. LOCATION (City, town, or county) <u>ORAN, MO.</u>
24. FUNERAL DIRECTOR <u>EARL J. SMITH F. H.</u>		ADDRESS <u>ORAN, MO.</u>	25. DATE RECD. BY LOCAL REG. <u>3-10-62</u>	26. REGISTRAR'S SIGNATURE <u>Irma Kasten</u>

(Licensed Embalmer's Statement on Reverse Side)

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
 DATE AMENDED  
 INSTEAD OF  
 DOCUMENT  
 MEDICAL CERTIFICATION  
 SHOULD READ  
 BY AFFIDAVIT OF

**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 *Earl J. Smith*

Licensed Embalmer No. 2676

P. O. Address *Oron 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.