

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=62-006380
STATE FILE NUMBER

AMENDED

Registration District No. 141 Primary Registration District No. 3025 Registrar's No. 30

FILED FEB 20 1962

1. PLACE OF DEATH a. COUNTY <u>Howell</u>			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Howell</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>West Plains</u>		Length of stay in 1b <u>hrs.</u>	c. CITY OR TOWN <u>West Plains</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>Memorial Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>210 Cherry</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Emma</u> Middle <u>Mittendorf</u> Last <u></u>			4. DATE OF DEATH Month <u>February</u> Day <u>12</u> Year <u>1962</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>wht.</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>2-4-1879</u>	9. AGE (last birthday) <u>83 yrs.</u>	IF UNDER 1 YEAR Months <u></u> Days <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>nurse</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Proctor, W. Va.</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>	
13a. FATHER'S NAME <u>Edward? Powell</u>		13b. MOTHER'S MAIDEN NAME xxxx <u>Sarah Briggs</u>		14. NAME OF HUSBAND OR WIFE <u>Fred Mittendorf</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>no</u>	17. INFORMANT Address <u>Glen Mittendorf, Koshkonong, 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> DUE TO (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>ARTERIO SCLEROSIS GENERALIZED</u> <u>Senility</u>				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.) <u>—</u>				
20c. TIME OF INJURY Hour <u></u> a.m. <u></u> p.m. <u></u>	Month <u></u> Day <u></u> Year <u></u>					
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.) <u>—</u>	20f. CITY, TOWN, OR LOCATION <u>—</u>	COUNTY <u>—</u>	STATE <u>—</u>		
21. I attended the deceased from <u>12:05</u> to <u>2</u> and last saw her <u>alive</u> on <u>2-12-62</u> Death occurred at <u>12:05</u> m on the date stated above, and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE <u>Dr. B. M. Wilson, M.D.</u>		22b. ADDRESS <u>West Plains, Mo.</u>		22c. DATE SIGNED <u>2-14-62</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>B</u>	23b. DATE <u>2-15-1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Howell Valley Cem.</u>	23d. LOCATION (City, town, or county) (State) <u>West Plains, Mo.</u>			
24. FUNERAL DIRECTOR <u>Robertson's, West Plains, Mo.</u>		ADDRESS <u>—</u>	25. DATE RECD. BY LOCAL REG. <u>2-16-62</u>	26. REGISTRAR'S SIGNATURE <u>Bessie Cook</u>		

DATE AMENDED
AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
INSTEAD OF
DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF
ITEM NO. SHOULD READ

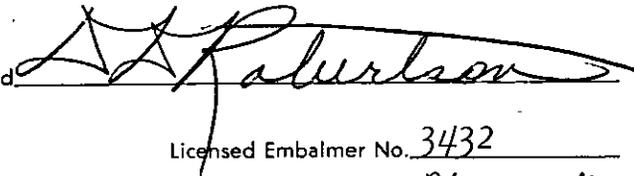
JUL 13 1962

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



Licensed Embalmer No. 3432

P. O. Address west Plains, Mo.

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.