

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-046163

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 53 Primary Registration District No. 3010 Registrar's No. 569

FILED JAN 2 1963

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>Cape Girardeau</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Cape Girardeau</u>		Length of stay in 1b <u>44 years</u>	c. CITY OR TOWN <u>Cape Girardeau</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Southeast Mo. Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>1601 Bessie Street</u>
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print) First <u>TESSIE</u> Middle <u>Mae</u> Last <u>JUDEN</u>			4. DATE OF DEATH Month <u>December</u> Day <u>24</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 checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>2/27/1898</u>	9. AGE (last birthday) <u>64</u>	IF UNDER 1 YEAR Months <u>9</u> Days <u>27</u> Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Practical Nurse, ret.</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Hospital</u>	11. BIRTHPLACE (City and state or country) <u>Bonne Terre, Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>U. S.</u>		
13a. FATHER'S NAME <u>James Foster</u>		13b. MOTHER'S MAIDEN NAME <u>Sarah Melissa Martin</u>		14. NAME OF HUSBAND OR WIFE <u>Donald M. Juden</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>[REDACTED]</u>	17. INFORMANT Address <u>Mrs. Grover Corbin Cape Gir., Mo.</u>		

18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion</u>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Arteriosclerotic heart disease</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 type="checkbox"/> No <input type="checkbox"/> Unknown

19. WAS AUTOPSY PERFORMED? YES <input 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 12-24/62 to 12-24-62 and last saw her alive on 12-24-62  
Death occurred at 3:30 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>J.H. Kasten M.D.</u> (Degree or title)	22b. ADDRESS <u>230 N. Sprigg Cape Girardeau, Mo.</u>	22c. DATE SIGNED <u>12-26-62</u>
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23a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>12-27-62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Lorimier Cemetery</u>	23d. LOCATION (City, town, or county) <u>Cape Girardeau, Missouri</u>
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24. FUNERAL DIRECTOR ADDRESS <u>Walther's Funeral Home</u> <u>Cape Gir. Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>12-28-62</u>	26. REGISTRAR'S SIGNATURE <u>Jimm Kasten</u>
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VS 300 Rev. 4/59

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2168

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

MAN 9 1963

**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

*David C. Buckel*

Licensed Embalmer No. 5085

P. O. Address Cap Hill, 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.