

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-009957

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 551

**FILED MAR 5 1963**

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Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Franklin</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Manchester</u>		Length of stay in 1b <u>6 mo.</u>	c. CITY OR TOWN <u>Pacific</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>Manchester Nursing Home</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>301 Columbus.</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>-</u> Last <u>Waldrop</u>			4. DATE OF DEATH Month <u>Feb</u> Day <u>18</u> Year <u>1963</u>
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</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>Jan. 24, 1868</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	9. AGE (last birthday) <u>95</u> IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.
11a. FATHER'S NAME <u>Ernst Bauer</u>		11. BIRTHPLACE (City and state or country) <u>Baden-Baden Germany</u>	
13a. FATHER'S NAME		13b. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>2</u>		14. NAME OF HUSBAND OR WIFE <u>deceased</u>	
16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>MANCHESTER RECORD ROOM</u>	
18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Failure</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Coronary Hypertrophy &amp; Dilatation</u> DUE TO (c) <u>Mitral Incompetence &amp; Stenosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>Don't Know</u> <u>Don't Know</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Diabetes Mellitus</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.)	
20c. TIME OF INJURY Hour . Month, Day, Year a.m. p.m.	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>Nov. 2, 1962</u> to <u>Feb. 15, 1963</u> and last saw him alive on <u>Feb. 15th, 1963</u> Death occurred at <u>11:05 P.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Russell W. Zeffery, M.D.</u>		22b. ADDRESS <u>Box 122, Manchester, Mo.</u>	22c. DATE SIGNED <u>2-19-63</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Feb 22 1963</u>	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY <u>Shawnee</u>	23d. LOCATION (City, town, or county) (State) <u>Shawnee, Kans.</u>
24. FUNERAL DIRECTOR ADDRESS <u>Mrs. John L. Thies Pacific, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>2-19-63</u>	26. REGISTRAR'S SIGNATURE <u>James M. Murphy, M.D.</u>

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK OR TYPEWRITER RIBBON

FORM 3 - 1964

**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 Ralph Ottmann

Licensed Embalmer No. 4808

P. O. Address Union, 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.