

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-019625

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 116 Primary Registration District No. 3020 Registrar's No. 137

STATE FILE NUMBER

FILED JUN 12 1963

VS 300 Rev. 4/59

DATE AMENDED

1 0365
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12 2-0
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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

USE BLACK INK OR TYPEWRITER RIBBON

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH
a. COUNTY *Franklin*
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN *Washington* Length of stay in lb *60 yrs.*
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION *St. Francis Hospital* Inside Limits Yes No

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE *Mo.* b. COUNTY *Franklin*
c. CITY OR TOWN *Washington* Inside Limits Yes No
d. STREET ADDRESS (If outside, give location) *317 Lafayette St.* Reside on Farm Yes No

3. NAME OF DECEASED (Type or print) First *FRANK* Middle *Esslinger* Last *Esslinger*
4. DATE OF DEATH Month *June* Day *9* Year *1963*

5. SEX *Male* 6. COLOR OR RACE *White* 7. Married Never Married Widowed Divorced 8. DATE OF BIRTH *10/4/1902* 9. AGE (last birthday) *60* IF UNDER 1 YEAR Months *7* Days *25* IF UNDER 24 HR Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) *Fastener Worker* 10b. KIND OF BUSINESS OR INDUSTRY *Ch Pipe Factory* 11. BIRTHPLACE (City and state or country) *Washington, Mo.* 12. CITIZEN OF WHAT COUNTRY *U. S. A.*

13. FATHER'S NAME *Louis H. Esslinger* 13b. MOTHER'S MAIDEN NAME *Therese Mueller* 14. NAME OF HUSBAND OR WIFE *None*

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) *NO* 16. SOCIAL SECURITY NO. 17. INFORMANT Address *Mrs. J. Whippley, 317 Lafayette Washington, Mo.*

18. CAUSE OF DEATH (Enter only one cause per line)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) *Pulmonary Edema* DUE TO (b) *Ch. Failure* INTERVAL BETWEEN ONSET AND DEATH *12 hours*
DUE TO (c) *Myocardial infarction* *Heart valve*
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I *mal nutrition* PART III. If deceased was female was there a pregnancy in last 90 days. Yes No Unknown

19. WAS AUTOPSY PERFORMED? YES NO 20a. ACCIDENT SUICIDE HOMICIDE 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 s.m. p.m.

20d. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 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 to and last saw her/him alive on . Death occurred at *2:10 P.* m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) *D. Mumm* 22b. ADDRESS *205 Elm Washington Mo* 22c. DATE SIGNED *6/10/63*

23a. BURIAL, CREMATION, REMOVAL (Specify) *Burial* 23b. DATE *June 13, 1963* 23c. NAME OF CEMETERY OR CREMATORY *St. Francis Cemetery* 23d. LOCATION (City, town, or county) (State) *Washington, Missouri*

24. FUNERAL DIRECTOR'S ADDRESS *Shelburne Co. Inc., Washington Mo* 25. DATE RECD. BY LOCAL REG. *6/10/63* 26. REGISTRAR'S SIGNATURE *Leola C. Tidman*

(Licensed Embalmer's Statement on Reverse Side)

JUN 12 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

Lester A. Pitt

Licensed Embalmer No. 3254

P. O. Address Washington, 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.