MISSOURI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

63-027858

STATE FILE NUMBER

Registration District No. 116 Primary Registration District No. 3020 Registrar's No. 176

FILED JUL 29 1963

DO NOT WRITE ON THIS STUB

AMENDED

VS 300 Rev. 4/59

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2 0365 2
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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

USE BLACK INK OR TYPEWRITER RIBBON

BY AFFIDAVIT OF DOCUMENT

1. PLACE OF DEATH
a. COUNTY FRANKLIN
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN WASHINGTON — Length of stay in 1b 1YR 11MO 25 Ho
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST FRANCIS — 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) 915 W 7TH — Reside on Farm Yes ☐ No ☑

3. NAME OF DECEASED (Type or print) First KATHERINE Middle Last VOSS

4. DATE OF DEATH Month 7 Day 23 Year 1963

5. SEX FEMALE
6. COLOR OR RACE White
7. Married ☐ Never Married ☑ Widowed ☐ Divorced ☐
8. DATE OF BIRTH 7-28-1961
9. AGE (last birthday) 1 YR — IF UNDER 1 YEAR Months 11 Days 25 — IF UNDER 24 HR Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE
10b. KIND OF BUSINESS OR INDUSTRY NONE
11. BIRTHPLACE (City and state or country) JEFFERSON City-Mo
12. CITIZEN OF WHAT COUNTRY U.S.A

13a. FATHER'S NAME Unknown
13b. MOTHER'S MAIDEN NAME SHIRLEY VOSS
14. NAME OF HUSBAND OR WIFE NONE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of servi
16. SOCIAL SECURITY NO.
17. INFORMANT Shirley Voss. Address 915 W 7th WASHINGTON-MO

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Appendicitis; abscess, peritonitis c/c bowel obstruction — INTERVAL BETWEEN ONSET AND DEATH 10 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)
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. ☐ 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 a.m. p.m. Month, Day, Year
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 July 22, 1963, to July 23, 1963 and last saw her alive on July 23, 1963
Death occurred at 5:45 P. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) John B Ryan M.D.
22b. ADDRESS Washington Mo
22c. DATE SIGNED 7-24-63

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE 7-25-1963
23c. NAME OF CEMETERY OR CREMATORY ST FRANCIS Cemetery
23d. LOCATION (City, town, or county) WASHINGTON (State) MO

24. FUNERAL DIRECTOR Nieburg & Vitt Inc ADDRESS Washington Mo
25. DATE RECD. BY LOCAL REG. 7/24/63
26. REGISTRAR'S SIGNATURE Leola C. Heidmann

(Licensed Embalmer's Statement on Reverse Side)

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. 4310

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.