

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-040492

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

Registration District No. 174 Primary Registration District No. 3035 Registrar's No. FS

FILED OCT 28 1963

DO NOT WRITE ON THIS STUB
 AMENDED

1. PLACE OF DEATH a. COUNTY LAFAYETTE		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE MISSOURI b. COUNTY LAFAYETTE	
b. CITY (If outside corporate limits, give TOWNSHIP, only) OR TOWN LEXINGTON		Length of stay in 1b 6 days	c. CITY OR TOWN MAYVIEW Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION LEXINGTON HOSP'T		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) North side Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) JOHN RINNE			4. DATE OF DEATH OCTOBER 15 - 1963			
5. SEX MALE	6. COLOR OR RACE WHITE	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 10-17-1879	9. AGE (last birthday) 83	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Self employed		10b. KIND OF BUSINESS OR INDUSTRY FARMER-MERCHANT		11. BIRTHPLACE (City and state or country) USA.		12. CITIZEN OF WHAT COUNTRY
13a. FATHER'S NAME FRITZ RINNE		13b. MOTHER'S MAIDEN NAME CAROLINA GIEBEL		14. NAME OF SPOUSE OR WIFE CLARA RINNE		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO.		17. INFORMANT Address CLARA RINNE MAYVIEW MO.		

18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) Peritonitis		6 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Carcinoma of rectum	Unknown
	DUE TO (c)	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Resection of tumor + anastomosis of rectum 10 days prior to death		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	
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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 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 10/4/63 to 10/14/63 and last saw him alive on 10/14/63 Death occurred at 11:50 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.				

22a. SIGNATURE (Degree or title) Wm. B. Riekhof, M.D.	22b. ADDRESS Higginsville, Mo.	22c. DATE SIGNED 10/16/63
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23a. BURIAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State)
BURIAL	10-18-1963	SALEM CHURCH	HIGGINSVILLE MO.

24. FUNERAL DIRECTOR ADDRESS WIEGERS-RIEKHOF HIGGINSVILLE MO 18 Oct. 1963	25. DATE RECD. BY LOCAL REG.	26. REGISTRAR'S SIGNATURE Thomas S. [Signature]
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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 BY AFFIDAVIT OF
 ITEM NO. SHOULD READ
 DATE AMENDED
 1 **0542**
 2 **0540**
 3
 4 **0**
 5 **1**
 6
 7 **0**
 8 **2**
 9 **154x**
 10
 11
 12 **2-0**
 13 **30**
 USE BLACK INK OR TYPEWRITER RIBBON

00000-100

OCT 29 1963

Body received 18 Oct. 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 Donald R. Wignard

Licensed Embalmer No. 5112

P. O. Address Higginsville, Md

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.