

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-042491

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 324 Primary Registration District No. 3072 Registrar's No. 192

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 324 Primary Registration District No. 3072 Registrar's No. 192

FILED NOV 12 1963					
1. PLACE OF DEATH					
a. COUNTY Saline					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Marshall					
Length of stay in 1b 3 years					
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION Fitzgibbon Hospital					
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>					
2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)					
a. STATE Minnesota COUNTY Hennepi					
c. CITY OR TOWN Minneapolis					
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>					
d. STREET ADDRESS (If outside, give location) 5226 Girard North					
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>					
3. NAME OF DECEASED			4. DATE OF DEATH		
First Middle Last			Month Day Year		
JULIA MARGARET BREGEL			November 5, 1963		
5. SEX		6. COLOR OR RACE		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/>	
Female		White		Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	
8. DATE OF BIRTH		9. AGE (last birthday)		IF UNDER 1 YEAR IF UNDER 24 HR	
12-17-1896		66		Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country)	
Ret. Seamstress		Clothing Manufacture		Luystown, Mo. USA	
13a. FATHER'S NAME			13b. MOTHER'S MAIDEN NAME		
Gustave Chevalier			Mary Harrison		
14. NAME OF HUSBAND OR WIFE			-----		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of serv)		16. SOCIAL SECURITY NO.		17. INFORMANT Address	
No				F. D. Powers-Arlington Heights, Ill.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) Pulmonary Edema INTERVAL BETWEEN ONSET AND DEATH 3 days					
DUE TO (b) Coronary Artery Failure 3 days					
DUE TO (c) Osteomyelitis Heart Area					
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 checked="" type="checkbox"/>		20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 <u>1962</u> to <u>11/5/63</u> and last saw her ^{her} _{him} alive on <u>11/5/63</u>		Death occurred at <u>4:10 pm.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title)		22b. ADDRESS		22c. DATE SIGNED	
<i>Wm. E. Roberts M.D.</i>		<i>Marshall Mo</i>		<i>11/6/63</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Removal		11-7-1963		St. Vincents Cemetery	
24. FUNERAL DIRECTOR ADDRESS		25. DATE RECD. BY LOCAL REG.		26. REGISTRAR'S SIGNATURE	
Campbell-Lewis Marshall, Mo.		11-6-'63		<i>Cecil G. Lead</i>	

VS 300
Rev. 4/59

1 *0975*
2 *28220*

3
4 *1*
5 *2*
6
7 *0*

8 *2*
9 *4200*

10
11
12 *1-0*
13 *30*

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

NOV 14 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

Phillip L. Smith

Licensed Embalmer No. 5163

P. O. Address Howland, Me.

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.