

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

MISSOURI DIVISION OF PUBLIC HEALTH AND WELFARE

Registration District No. 82 Primary Registration District No. 3017 Registrar's No. 0044064 STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

DEFILED 15 64

VS 300
Rev. 4/59

DATE AMENDED

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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

USE BLACK INK OR TYPEWRITER RIBBON

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>Cooper</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Cooper</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Boonville</u>		c. CITY OR TOWN <u>Boonville</u>	
Length of stay in 1b <u>80 yrs</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>519 E. High</u>		d. STREET ADDRESS (If outside, give location) <u>519 E. High</u>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>BERTHA VOLLRATH</u>			4. DATE OF DEATH Month <u>December</u> Day <u>6</u> Year <u>1964</u>
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>5/30/84</u>
9. AGE (last birthday) <u>80</u>		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) <u>Gen. duties</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hospital</u>	11. BIRTHPLACE (City and state or country) <u>Boonville, Mo.</u>
12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13a. FATHER'S NAME <u>Charles Vollrath</u>	
13b. MOTHER'S MAIDEN NAME <u>Pauline Kratz</u>		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 service) <u>no</u>		16. SOCIAL SECURITY NO. <u>unknown</u>	17. INFORMANT Address <u>Elsa Mannion Boonville, Mo.</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio-sclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>?</u>
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. <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 <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 _____ Death occurred at <u>about 10:00</u> <u>NO attendances</u> on _____ m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Dr. Deccaeger MD</u>		22b. ADDRESS <u>Boonville Mo</u>	22c. DATE SIGNED <u>12/8/64</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE <u>Dec. 9/64</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Walnut Grove Cem.</u>	23d. LOCATION (City, town, or county) <u>Boonville, Missouri</u>
24. FUNERAL DIRECTOR <u>B. W. Thacher</u>		ADDRESS <u>Boonville, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>12/8/64</u>
		26. REGISTRAR'S SIGNATURE <u>W. Hooper</u>	

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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 Berry W. Shaker

Licensed Embalmer No. 3944

P. O. Address Bonville, 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.