

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-044369

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 137 Primary Registration District No. _____ Registrar's No. 286

STATE FILE NUMBER

FILED JAN 2 1962

1. PLACE OF DEATH a. COUNTY <u>Henry</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> COUNTY <u>Henry</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Windsor</u>		Length of stay in lb <u>2 years</u>	c. CITY OR TOWN <u>Windsor</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>Windsor Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>206 E. Jackson</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>Frances</u> Last <u>Marzolf</u>	4. DATE OF DEATH Month <u>December</u> Day <u>27</u> Year <u>1961</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 checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>7/1/1875</u>	9. AGE (last birthday) <u>86</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>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Sterling, Illinois</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
---	-----------------------------------	---	--

13a. FATHER'S NAME <u>Jacob Fisher</u>	13b. MOTHER'S MAIDEN NAME <u>Margaret Watson</u>	14. NAME OF HUSBAND OR WIFE <u>John H. Marzolf</u>
---	---	---

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>None</u>	17. INFORMANT <u>Lester Marzolf, 1617 W. 39 St. No. _____, Kansas City, Mo.</u>
---	--	--

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Uremia</u>		<u>24 hrs</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Renal failure - Uremia</u>	<u>72 hrs</u>
	DUE TO (c) <u>Pneumonia (Bronchial)</u>	<u>7 days</u>

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Parkinson Disease - Generalized arteriosclerosis</u>	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 1959 to 27 December, 1961 and last saw him alive on 27 December, 1961
Death occurred at 6:40 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Bernard Buchard</u> (Degree or title)	22b. ADDRESS <u>116 South main Windsor, Missouri</u>	22c. DATE SIGNED <u>12/27/61</u>
---	--	----------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>12-28-1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Neoma Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Glen Elder Kansas</u>
---	--------------------------------	---	---

24. FUNERAL DIRECTOR <u>Clifford Gouge Windsor, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>Dec 28, 1961</u>	26. REGISTRAR'S SIGNATURE <u>Waldred Bigeman</u>
--	---	---

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

JAN 3 1962

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 Clifford Gouge

Licensed Embalmer No. 5014

P. O. Address Windsor, 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.