

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 137 Primary Registration District No. 4218 Registrar's No. 18819399 STATE FILE NUMBER

JNF FILED 007 65

VS 300  
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

|  |   |   |   |
|--|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Henry</u>  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Mo.</u> b. COUNTY <u>Henry</u>                         |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <u>Windsor</u>  |   | Length of stay in 1b<br><u>3 Yrs</u>  | c. CITY OR TOWN <u>Urich</u>  |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <u>Windsor Nursing Home</u>   |   | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  | d. STREET ADDRESS (If outside, give location)<br>Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>                            |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Della M.</u> Middle <u>Gray</u> Last <u>Fritz</u>  |   | 4. DATE OF DEATH<br>Month <u>5</u> Day <u>29</u> Year <u>65</u>   |   |
| 5. SEX <u>Fe</u>   | 6. COLOR OR RACE <u>White</u>   | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>5-6-74</u>  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Housewife</u>  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Home</u>  | 11. BIRTHPLACE (City and state or country)<br><u>Urich, Mo.</u>   |
| 13a. FATHER'S NAME<br><u>I. W. Gray</u>  |   | 13b. MOTHER'S MAIDEN NAME<br><u>Jane Proctor</u>  | 14. NAME OF HUSBAND OR WIFE<br><u>George Fritz</u>  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give war or dates of service)  |   | 16. SOCIAL SECURITY NO.   | 17. INFORMANT<br>Address<br><u>Jessie Gray, Lorraine, Ohio.</u>   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Circulatory Collapse</u><br>DUE TO (b) <u>Senility</u><br>DUE TO (c) <u>Arteriosclerosis Generalized</u> |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>2 days</u><br><u>5 yrs</u><br><u>40 yrs</u>  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)  |   |   | PART III. Deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |
| 19. WAS AUTOPSY PERFORMED?<br>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<br>Hour <u>9:25 p.m.</u> Month, Day, Year <u>May 29, 1965</u>  |   | 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<br><u>Urich, Mo.</u>   |   |
| 21. I attended the deceased from <u>1962</u> to <u>May 29, 1965</u> and last saw her alive on <u>May 28, 1965</u><br>Death occurred at <u>9:25 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated. |   |   |   |
| 22a. SIGNATURE<br><u>William J. Smith M.D.</u> (Degree or title)   |   | 22b. ADDRESS<br><u>Windsor, Mo.</u>   |   |
| 22c. DATE SIGNED<br><u>5/30/65</u>   |   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   | 23b. DATE<br><u>6-1-65</u>  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Urich</u>  | 23d. LOCATION (City, town, or county)<br><u>Urich, Mo.</u> (State)  |
| 24. FUNERAL DIRECTOR<br><u>Snow's Funeral Home, Urich, Mo</u>  |   | 25. DATE RECD. BY LOCAL REG.<br><u>5-31-1965</u>  | 26. REGISTRAR'S SIGNATURE<br><u>Mildred Begim</u>   |

USE BLACK INK OR TYPEWRITER RIBBON

**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 Merle Snow

Licensed Embalmer No. 4034

P. O. Address Urich, 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.

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