

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

12639

State File No. ....

BIRTH NO. .... REG. DIST. NO. 310 PRIMARY REG. DIST. NO. 3058 Registrar's No. 225

1. PLACE OF DEATH a. COUNTY <u>Lincoln St Charles</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Lincoln</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <u>Rural Hawkpoint</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <u>Rural Hawkpoint</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>St Joseph Hospital</u>		d. STREET ADDRESS (If rural, give location) <u>2 mi west of Hawkpoint mo</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>ROSIE</u>	b. (Middle) <u>M.</u>	c. (Last) <u>FLOHR</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>Nov 21 51</u>
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>	8. DATE OF BIRTH <u>July 4, 1878</u>	9. AGE (In years last birthday) <u>73</u>	IF UNDER 1 YEAR Months <u>4</u>	IF UNDER 12 HRS. Days <u>7</u>	IF UNDER 1 MIN. Hours <u></u>	IF UNDER 1 MIN. Min. <u></u>
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 <u>at home</u>		11. BIRTHPLACE (State or foreign country) <u>Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		

13a. FATHER'S NAME <u>Henry Sontag</u>	13b. MOTHER'S MAIDEN NAME <u>Augusta Weber</u>	14. NAME OF HUSBAND OR WIFE <u>Otto Flohr</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'S SIGNATURE OR NAME ADDRESS <u>Otto Flohr Hawkpoint mo</u>

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH  <u>3 yrs</u>  <u>10 yrs</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Hypertensive Cardio renal</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>vascular disease</u> DUE TO (c) <u>Arteriosclerosis</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9 Nov., 1951, to 21 Nov., 1951, that I last saw the deceased alive on 21 Nov., 1951, and that death occurred at 5:25 p. m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Ed Sawyer M.D.</u>	23b. ADDRESS <u>114 N. Main St. Charles Mo 21 Nov 51</u>	23c. DATE SIGNED
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>Nov 9 1951</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Hawkpoint Cemetery Hawkpoint mo</u>	24d. LOCATION (City, town, or county) (State)
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DATE REC'D BY LOCAL REG. <u>11-24-51</u>	REGISTRAR'S SIGNATURE <u>Bannis Hamilton</u>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Wayne McBooy Troy Mo</u>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

File No. \_\_\_\_\_  
DISTRICT HEALTH OFFICE No. 4  
NOV 26 1951

RECEIVED

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 .....  
Student Embalmer

Signed Wayne M. Coy  
Licensed Embalmer No. 3586

P. O. Address Long Rd.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.