

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

10903

FILED APR 26 1955

State File No. _____

| | | | | | | | |
|--|--|---|--|--|--|---|--|
| BIRTH NO. _____ | | REG. DIST. NO. <u>10</u> | | PRIMARY REG. DIST. NO. <u>3002</u> | | Registrar's No. <u>78</u> | |
| 1. PLACE OF DEATH a. COUNTY <u>Audrain</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before death) a. STATE <u>Missouri</u> b. COUNTY <u>Audrain</u> | | | |
| b. CITY (If outside corporate limits, write RURAL and give township) <u>Mexico</u> | | c. LENGTH OF STAY (length and place) <u>1 1/2 days</u> | | c. CITY (If outside corporate limits, write RURAL and give township) <u>Martinsburg</u> | | | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Audrain County Hospital</u> | | | | d. STREET ADDRESS (If rural, give location) <u>no street address</u> | | | |
| 3. NAME OF DECEASED (Type or Print) a. (First) <u>ELIZABETH</u> | | b. (Middle) <u>JOSEPHINE</u> | | c. (Last) <u>FENNEWALD</u> | | 4. DATE OF DEATH (Month) (Day) (Year) <u>Apr. 17 1955</u> | |
| 5. SEX <u>Female</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u> | | 8. DATE OF BIRTH <u>Sept. 4 1882</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House work</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>House work</u> | | 11. BIRTHPLACE (State or foreign country) <u>Audrain County Missouri</u> | | 12. CITIZENRY OF WHAT COUNTRY? <u>A.</u> | |
| 13a. FATHER'S NAME <u>Henry Paschang</u> | | | 13b. MOTHER'S MAIDEN NAME <u>Thresa Kuensting</u> | | | 14. NAME OF HUSBAND OR WIFE <u>Deceased</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 <u>500-24-0078</u> | | 17. INFORMANT'S SIGNATURE OR NAME <u>Therese Fennewald</u> | | ADDRESS <u>Martinsburg</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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral thrombosis</u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>4-16-55</u> |
| | | | | ANTECEDENT CAUSES <u>Hypertensive cardiac vascular disease</u> | | | DUE TO (b) <u>2 weeks</u> |
| | | | | DUE TO (c) | | | |
| | | | | II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>None</u> | | | |
| 19a. DATE OF OPERATION <u>X</u> | | 19b. MAJOR FINDINGS OF OPERATION <u>443 X</u> | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>X</u> | | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>X</u> | | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>Martinsburg Audrain Mo</u> | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) <u>X</u> | | 21e. INJURY OCCURRED WHILE AT WORK? (Specify) <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? <u>X</u> | | | |
| 22. I hereby certify that I attended the deceased from <u>4-16-55</u> , 19 <u>55</u> , to <u>4-17</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>4-17</u> , 19 <u>55</u> , and that death occurred at <u>2 P.m.</u> , from the causes and on the date stated above. | | | | | | | |
| 23a. SIGNATURE (Degree or title) <u>Harry J. O'Brien M.D.</u> | | | | 23b. ADDRESS <u>Mexico, Mo</u> | | 23c. DATE SIGNED <u>4-20-55</u> | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24b. DATE <u>4/20/55</u> | | 24c. NAME OF CEMETERY OR CREMATORY <u>St. Joseph Cemetery</u> | | 24d. LOCATION (City, town, or county) (State) <u>Martinsburg, Audrain, Mo</u> | |
| DATE REC'D BY LOCAL REG. <u>April 20 1955</u> | | REGISTRAR'S SIGNATURE <u>Blanche Neely</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE <u>A.B. Wells</u> | | ADDRESS <u>Hollersville Mo</u> | |

RECORD IN A PERMANENT RECORD

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 _____

working under my personal supervision.

Student Embalmer No. _____

Signed _____

Signed _____
Student Embalmer

Licensed Embalmer No. _____

P. O. Address _____

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

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