

FILED JUN 1 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

16164

State File No.

BIRTH NO. _____		REG. DIST. NO. <u>258</u>		PRIMARY REG. DIST. NO. <u>5882</u>		Registrar's No. <u>3</u>	
1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
a. COUNTY <u>OSAGE</u>		a. STATE <u>MISSOURI</u>		b. COUNTY <u>OSAGE</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Meta - Wash.</u>		c. LENGTH OF STAY (in this place) <u>LIFE</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Meta</u>		<u>0760</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Meta Mo. RD</u>				d. STREET ADDRESS (If rural, give location) <u>R.D.</u>			
3. NAME OF DECEASED			4. DATE OF DEATH				
a. (First) <u>CARL</u>		b. (Middle) <u>HENRICH</u>	c. (Last) <u>WACHTENDORF</u>		(Month) <u>MAY</u>	(Day) <u>26</u>	(Year) <u>1955</u>
(Type or Print)							
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>Feb-8-1869</u>	9. AGE (In years last birthday) <u>86</u>	IF UNDER 1 YEAR Months <u>3</u> Days <u>16</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>retired</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u></u>	
13a. FATHER'S NAME <u>Claus Wachtendorf</u>			13b. MOTHER'S MAIDEN NAME <u>Anna Johnson</u>		14. NAME OF HUSBAND OR WIFE <u>Sophia Mueller</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></u>	17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Carl Wachtendorf</u>			ADDRESS <u>Meta</u>	
18. CAUSE OF DEATH				MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
Enter only one cause per line for (a), (b), and (c)				I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary Thrombosis</u>			<u>Lat.</u>
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.				ANTECEDENT CAUSES			
				DUE TO (b) <u></u>			
				DUE TO (c) <u></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 type="checkbox"/>
							<u>4201</u>
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)		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 _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>E. H. Morton</u>			23b. ADDRESS <u>Corners Linn, Mo.</u>			23c. DATE SIGNED <u>5/27/55</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>5/29/55</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Babbtown Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Osage County Mo.</u>		
DATE REC'D BY LOCAL REG. <u>May 28, 1955</u>		REGISTRAR'S SIGNATURE <u>Rose Rowan</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Walter P. Helges</u>		ADDRESS <u>Meta, Mo.</u>	

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE 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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed _____

Licensed Embalmer No. *42631*

P. O. Address *Idaho, Mo*

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.