

FILED MAY 18 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

17462

State File No.

BIRTH NO. _____ REG. DIST. NO. 314 PRIMARY REG. DIST. NO. 4437 Registrar's No. 37

1. PLACE OF DEATH a. COUNTY <u>St. Clair</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). ---a. STATE <u>Missouri</u> b. COUNTY <u>St. Clair</u> <u>0930</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Osceola</u>	c. LENGTH OF STAY (in this place) <u>weeks</u>	c. CITY OR TOWN <u>Vista</u>	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> <u>0</u>
d. FULL NAME OF HOSPITAL OR INSTITUTION		• STREET ADDRESS (If rural, give location)	

3. NAME OF DECEASED (Type or Print)	a. (First) <u>Barbara</u>	b. (Middle) <u>--</u>	c. (Last) <u>Todd</u>	4. DATE OF DEATH (Month) <u>8</u> (Day) <u>22</u> (Year) <u>1956</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>Widowed</u>	8. DATE OF BIRTH <u>June 9, 1879</u>	9. AGE (In years last birthday) <u>76</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeping</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) <u>St. Clair County Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13a. FATHER'S NAME <u>Pete Kauffman</u>	13b. MOTHER'S MAIDEN NAME <u>Sallie Cole</u>	14. NAME OF HUSBAND OR WIFE <u>Deceased</u>
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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 <u>Charley Kauffman, Osceola Mo;</u>	ADDRESS
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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, athermia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>hrs</u> <u>4 yrs</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>cerebral hemorrhage</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>hypertension</u> DUE TO (c) _____		
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	<u>3 31x</u>	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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from 1952, to May 10, 1952, that I last saw the deceased alive on March 1952, and that death occurred at 2:10 P.M. from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Ruth Seewers M.D.</u>	23b. ADDRESS <u>Osceola Mo</u>	23c. DATE SIGNED <u>5-10-56</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>5/12/56</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Kings Prairie</u>	24d. LOCATION (City, town, or county) (State) <u>Gerster Missouri</u>
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DATE REC'D BY LOCAL REG. <u>5-16-56</u>	REGISTRAR'S SIGNATURE <u>Ruth Seewers</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Goodrich Funeral Home, Osceola Mo.</u>	ADDRESS
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(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

0.300
0.48

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 *Paul J. [unclear]*.....

Licensed Embalmer No. *399*.....

P. O. Address *[unclear]*.....

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..