

FILED NOV 7-1956

THE DIVISION OF HEALTH OF THE STATE OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **33602**

BIRTH NO. _____ REG. DIST. NO. 119 PRIMARY REG. DIST. NO. 5443 Registrar's No. 48

1. PLACE OF DEATH a. COUNTY Gasconade		2. USUAL RESIDENCE (Where deceased lived; if institution: residence before admission). a. STATE Missouri b. COUNTY Gasconade	
b. CITY (If outside corporate limits, write RURAL and give township) Roark Township	c. LENGTH OF STAY (In this place)	c. CITY OR TOWN Roark	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION Frene Valley Home		e. STREET ADDRESS (If rural, give location)	

03700

3. NAME OF DECEASED (Type or Print) a. (First) Charles b. (Middle) Hans c. (Last)			4. DATE OF DEATH (Month) (Day) (Year) Oct. 27 1956		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH March 26, 1882		9. AGE (In years last birthday) 74 If UNDER 1 YEAR: Months 7 Days 1 If UNDER 24 HRS.: Hours 1 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY For farmers		11. BIRTHPLACE (City and State or Foreign Country) Hope, Mo.	
13a. FATHER'S NAME William Hans			13b. MOTHER'S MAIDEN NAME Gertrude Von Stratten		14. NAME OF HUSBAND OR WIFE never married

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown		16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. August Hans Hermann Mo.		
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic heart disease		INTERVAL BETWEEN ONSET AND DEATH 10 years
	ANTECEDENT CAUSES DUE TO (b) _____ 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	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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) 4200
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 9-11, 1957, to 10-27, 1956, that I last saw the deceased alive on 10-25, 1956, and that death occurred at 9 P m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Cecil T. Shaw, M.D.	23b. ADDRESS Hermann, Mo.	23c. DATE SIGNED 10-29-56
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Oct. 30, 1956	24c. NAME OF CEMETERY OR CREMATORY City	24d. LOCATION (City, town, or county) (State) Hermann, Mo.
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DATE REC'D BY LOCAL REG. 10/29/56	REGISTRAR'S SIGNATURE Delmas Becken	EMERALD DIRECTOR'S SIGNATURE Edmund Rediger	ADDRESS Hermann, Mo.
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(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.....
Signature of Student Embalmer

Signed *Emmet Ruediger*

Licensed Embalmer No. 2044

P. O. Address ..Herman.n.,...

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.