Health, Welfare Public Service

300
1-56

FILED DEC 3 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER 32566

Registration District No. 116 Primary Registration District No. 3020 Registrar's No. 9

1. PLACE OF DEATH
a. COUNTY FRANKLIN
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN WASHINGTON — Inside Limits Yes X No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) ST. FRANCIS HOSPITAL — Length of stay in 1b 36 hrs

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo b. COUNTY GASCONADE
c. CITY OR TOWN 0370 — Inside Limits Yes ☐ No X
d. STREET ADDRESS (If outside, give location) 4 mi. SE. of HERMANN — Reside on Farm Yes X No ☐

3. NAME OF DECEASED (Type or print) First Middle Last: LOUISA CAROLINE DANUSER
4. DATE OF DEATH Month Day Year: NOV. 24 - 1956
5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: JAN. 30 - 1875
9. AGE (In years last birthday): 81 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWORK
10b. KIND OF BUSINESS OR INDUSTRY: Household
11. BIRTHPLACE (City and state or country): HERMANN Mo
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: CHRISTIAN DANUSER
14. MOTHER'S MAIDEN NAME: VERENA BOTTERMAN
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO — (If yes, give war or dates of service) —
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT: GUST. SOEDMEYER — Address: HERMANN Mo

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of stomach — INTERVAL BETWEEN ONSET AND DEATH: 6 mo
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) ____ DUE TO (c) ____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 151X
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from 1-10-50, to 11-24-56 and last saw her/him alive on 11-24-56
Death occurred at 4:30 P m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Carvel T. Shaw, MD
22b. ADDRESS: Hermann, Mo
22c. DATE SIGNED: 11-26-56

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE: 11/27/56
23c. NAME OF CEMETERY OR CREMATORY: HERMANN CEMETERY
23d. LOCATION (City, town, or county) (State): HERMANN Mo

24. FUNERAL DIRECTOR: HUGO H. BLUMER — ADDRESS: HERMANN Mo
25. DATE RECD. BY LOCAL REG.: 11/26/56
26. REGISTRAR'S SIGNATURE: T. L. Heidmann & L. C. Heidmann

(Licensed Embalmer's Statement on Reverse Side)

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

9-0

MAY 24 1957

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was em

by me, or by ....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed.....

Licensed Embalmer No. 316

P. O. Address Hermann

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