

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

5451

State File No. ....

No. 300  
10.48

FILED FEB 20 1957

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 187 PRIMARY REG. DIST. NO. 3040 Registrar's No. 66

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

1. PLACE OF DEATH a. COUNTY <u>Livingston</u>		2. USUAL RESIDENCE (Where deceased lived. If Institution: residence before death) a. STATE <u>Missouri</u> b. COUNTY <u>Livingston</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Chillicothe</u>	c. LENGTH OF STAY (If in place) <u>3 days</u>	c. CITY OR TOWN <u>Wheeling</u>	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION: <u>Chillicothe Hospital</u>		e. STREET ADDRESS (If rural, give location) <u>Rural 2½ Mi. N. of Wheeling</u>	

3. NAME OF DECEASED (Type or Print)	a. (First) <u>B ERTHA</u>	b. (Middle) <u>ESTELLA</u>	c. (Last) <u>ACHENBACH</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>Feb. 4 1957</u>
-------------------------------------	---------------------------	----------------------------	----------------------------	--

5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Dec. 27, 1879</u>	9. AGE (In years last birthday) <u>77</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
----------------------	-------------------------------	---	---------------------------------------	---	---	---

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Taylorville, Ill.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
---	--	---	--

13a. FATHER'S NAME <u>Orren Curvey</u>	13b. MOTHER'S MAIDEN NAME <u>Ann Roberts</u>	14. NAME OF HUSBAND OR WIFE <u>John H. Achenbach</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>NONE</u>	17. INFORMANT'S SIGNATURE OR NAME <u>John H. Achenbach</u>	ADDRESS <u>Wheeling, Mo.</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		INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Acute Coronary Occlusion</u>		
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.  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) <u>4201</u> <u>2</u>
--	--	--

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) _____	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 Feb 27, 1957, to Feb 4, 1957, that I last saw the deceased alive on Feb 4, 1957, and that death occurred at 1:45 p.m., from the causes and on the date stated above.

23a. SIGNATURE <u>Joseph F. Hale M.D.</u>	(Degree or title) <u>M.D.</u>	23b. ADDRESS <u>Chillicothe, Mo.</u>	23c. DATE SIGNED <u>2-5-57</u>
---	-------------------------------	--------------------------------------	--------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>2-6-57</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Wheeling Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>Wheeling, Missouri</u>
---	-------------------------	---	---

DATE REC'D BY LOCAL REG. <u>2-5-57</u>	REGISTRAR'S SIGNATURE <u>Fran cis B Neill</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>NORMAN FUNERAL HOME:</u>	ADDRESS <u>Chillicothe, Mo.</u>
--	---	--	---------------------------------

JUL 16 1958

---

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 *Joseph M. Libero*  
Licensed Embalmer No....4769

P. O. Address Chillicothe

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