

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No. **20493**

FILED JUL 10 1957

BIRTH NO. _____ REG. DIST. NO. **77** PRIMARY REG. DIST. NO. **3016** Registrar's No. **281**

1. PLACE OF DEATH a. COUNTY COLE		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY OSAGE	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN JEFFERSON MO.		c. CITY OR TOWN LINN	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION: St. Mary's Hospital		e. STREET ADDRESS (If rural, give location) 0760	

3. NAME OF DECEASED (Type or Print) a. (First) Elizabeth b. (Middle) Mary c. (Last) Niekamp			4. DATE OF DEATH (Month) (Day) (Year) July 6 1957		
5. SEX female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH March 7 1885	9. AGE (In years last birthday) 72	IF UNDER 1 YEAR Days 3 YEAR 29 IF UNDER 2 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -----	11. BIRTHPLACE (City and State or Foreign Country) Frankenstine Mo		12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME Martine Schaefer		13b. MOTHER'S MAIDEN NAME Gertrude Bierbaum		14. NAME OF HUSBAND OR WIFE Wm/ H. Niekamp	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 491-24-1460		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. Louis Boes Linn, Mo	

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, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Paralytic Pleur Pot operative			21 days
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Small bowel obstruction			23 days
DUE TO (c) Acute Myeloid Leukemia		23 days		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 756.2				

19a. DATE OF OPERATION June 15, 1957		19b. MAJOR FINDINGS OF OPERATION Acute Myeloid Leukemia with small bowel obstruction		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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)	
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 **June 13, 1957**, to **July 6, 1957**, that I last saw the deceased alive on **July 5, 1957**, and that death occurred at **2:30 p.m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) L. B. Klebla M.D.		23b. ADDRESS Jefferson City Mo		23c. DATE SIGNED 7-6-57	
24a. BURIAL, CREMATION, REMOVAL (Specify) burial		24b. DATE 7-8-57		24c. NAME OF CEMETERY OR CREMATORY St George Cemetery	
				24d. LOCATION (City, town, or county) (State) Linn Mo.	

DATE REC'D BY LOCAL REG. 6 July 1957		REGISTRAR'S SIGNATURE R.P. Norris, MD MR.		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Vernon Morten Linn Mo	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

VS SEP 9 1960

SEP 12 1951

LAUG 14 1951

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 *Vernon M. Norton*.....

Licensed Embalmer No... *4120*

P. O. Address *Levin 7*.....

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.