

FILED JUL 29 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

25231 STATE FILE NUMBER

Registration District No. 174 Primary Registration District No. 3055 Registrar's No. 78

|  |                               |  |  |  |  |  |
|--|-------------------------------|--|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>LAFAYETTE</b>  |                               |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>MISSOURI</b> b. COUNTY <b>LAFAYETTE</b> |  |  |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>LEXINGTON</b>   |                               | Inside Limits<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>   | c. CITY OR TOWN <b>CORDER</b>  |  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                   |  |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>CORDLOW REST HOME</b>   |                               | Length of stay in 1b<br><b>14 MONTHS</b>   | d. STREET ADDRESS <b>P.O. BOX 44</b>   |  | (If outside, give location) Reside on Farm<br>Yes <input type="checkbox"/> No <input type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>ADOLPH</b> Middle <b>AUGUST</b> Last <b>DEHRKE</b>   |                               |  | 4. DATE OF DEATH<br>Month <b>July</b> Day <b>20</b> Year <b>1957</b>   |  |  |  |
| 5. SEX <b>MALE</b>   | 6. COLOR OR RACE <b>WHITE</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>MARCH 21, 1907</b>  | 9. AGE (In years last birthday) <b>50</b>                      | IF UNDER 1 YEAR<br>Months Days Hours Min.  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NEVER WORKED</b>  |                               | 10b. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>  | 11. BIRTHPLACE (City and state or country) <b>FLORENCE, MO</b>   |  | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  |
| 13. FATHER'S NAME <b>CHARL DEHRKE</b>  |                               |  | 14. MOTHER'S MAIDEN NAME <b>MARIA DEHRKE</b>   |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>  |                               | 16. SOCIAL SECURITY NO. <b>NO</b>  | 17. INFORMANT Address<br><b>LUENAA SCHTOEBER SLATER</b>  |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Bronchial pneumonia</b>   |                               |  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>2 weeks</b>   |  |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.<br>DUE TO (b) <del>Stroke</del>   |                               |  |  |  |  |  |
| DUE TO (c)   |                               |  |  |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><b>Grant mal Epilepsy</b>  |                               |  |  |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>         |  |
| 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>  |                               |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |  |  |
| 20c. TIME OF INJURY<br>Hour Month, Day, Year<br>a. m. p. m.  |                               |  |  |  |  |  |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |                               | 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 <b>June 25</b> to <b>July 20-57</b> and last saw her alive on <b>July 18-57</b><br>Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated. |                               |  |  |  |  |  |
| 22a. SIGNATURE <b>W.K. Koprowski M.D.</b> (Degree or title)  |                               |  | 22b. ADDRESS <b>Higginville Mo</b>   |  | 22c. DATE SIGNED <b>July 23-57</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>  | 23b. DATE <b>7/22/57</b>      | 23c. NAME OF CEMETERY OR CREMATORY <b>ZION LUTHERAN</b>  |  | 23d. LOCATION (City, town, or county) <b>CORDER MO</b> (State) |  |  |
| 24. FUNERAL DIRECTOR ADDRESS<br><b>E. S. James Conordia, Mo</b>  |                               | 25. DATE RECD. BY LOCAL REG. <b>7/25/57</b>  |  | 26. REGISTRAR'S SIGNATURE<br><b>Winema E Eastbrooks MO</b>     |  |  |

**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 me Student-Embalmer No. ....  
working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed E. S. James.....

Licensed Embalmer No. 209

P. O. Address Corvallis

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.