

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

35292

State File No. \_\_\_\_\_

FILED NOV 4 1957

BIRTH NO. _____		REG. DIST. NO. <u>100</u>		PRIMARY REG. DIST. NO. <u>3018</u>		Registrar's No. <u>85</u>			
1. PLACE OF DEATH a. COUNTY <u>DENT</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) -a. STATE <u>MISSOURI</u>				b. COUNTY <u>DENT</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>SALEM</u>		c. LENGTH OF STAY (in this place) <u>1 day</u>		c. CITY OR TOWN <u>RURAL-SPRINGCREEK TWP.</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>HART CLINIC</u>				e. STREET ADDRESS (If rural, give location) <u>Route 1</u>				<u>6300</u>	
3. NAME OF DECEASED (Type or Print) a. (First) <u>BERNARD</u>			b. (Middle) <u>FRANK</u>		c. (Last) <u>NOTHAUS</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>OCT. 27 1957</u>		
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>		8. DATE OF BIRTH <u>AUG. 6, 1880</u>		9. AGE (In years last birthday) <u>77</u> If UNDER 1 YEAR: Months _____ Days _____ If UNDER 1 HRs. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>AGRICULTURE</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>CARLYLE, ILLINOIS</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>ANTONE NOTHAUS</u>			13b. MOTHER'S MAIDEN NAME <u>MARY SCHROEDER</u>			14. NAME OF HUSBAND OR WIFE <u>ANNA NOTHAUS</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>489-42-7513</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Louis NOTHAUS, Rte 1, Salem, 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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral hemorrhage</u>  ANTECEDENT CAUSES Morbid 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.						INTERVAL BETWEEN ONSET AND DEATH <u>25 Oct 57</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION  <u>331X</u>						20. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
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 <u>Feb. 25, 1946</u> to <u>Oct. 27, 1957</u> , that I last saw the deceased alive on <u>Oct. 27, 1957</u> , and that death occurred at <u>7:5 A.M.</u> , from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title) <u>Max L. Warfel, M.D.</u>				23b. ADDRESS <u>Salem, Missouri</u>			23c. DATE SIGNED <u>10/28/57</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24b. DATE <u>OCT. 29, 1957</u>		24c. NAME OF CEMETERY OR CREMATORY <u>CEDAR GROVE CEMETERY</u>		24d. LOCATION (City, town, or county) (State) <u>SALEM MISSOURI</u>			
DATE REC'D BY LOCAL REG. <u>10/28/57</u>		REGISTRAR'S SIGNATURE <u>M. M. Hart, M. D. by P. M.</u>			25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Max L. Warfel Salem, Mo.</u>				

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

538

NOV 12 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.....*Max L. Warfel*

Licensed Embalmer No. *4170*

P. O. Address *Salem, Mo*

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.