

Health,  
Welfare  
Public  
Service

FILED MAR 25 1958

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-008686  
STATE FILE NUMBER

Registration District No. 4 Primary Registration District No. 4012 Registrar's No. 26

100  
57  
30

1. PLACE OF DEATH a. COUNTY <u>Adairson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Adairson</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Rock Port Mo</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Rock Port Mo</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION		Length of stay in lb	d. STREET ADDRESS (If outside, give location) <u>805</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Lulu</u> Middle <u>Mar</u> Last <u>Backhaus</u>			4. DATE OF DEATH Month <u>Mar.</u> Day <u>16</u> Year <u>1958</u>		
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June - 17, 1886</u>		9. AGE (In years last birthday) <u>71</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Phelps City Mo</u>		12. CITIZEN OF WHAT COUNTRY?
13a. FATHER'S NAME <u>Todd King</u>		13b. MOTHER'S MAIDEN NAME <u>Viola Hamilton</u>		14. NAME OF HUSBAND OR WIFE <u>Wm. Backhaus</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 <u>Wm. Wm. Backhaus</u> Address <u>Rock Port Mo</u>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Generalized Arteriosclerosis.</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>5 Mo</u> <u>10 YRS.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		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.) <u>4201</u>		
20c. TIME OF INJURY Hour _____ Month, Day, Year _____ a.m. _____ p.m. _____					
20d. INJURY OCCURRED WHILE AT <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 <u>Nov. 1956</u> to <u>March 1958</u> and last saw her alive on <u>Jan 3<sup>rd</sup>, 1958</u> Death occurred at _____ <u>3 A</u> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>James R. Allen, M.D.</u> (Degree or title)			22b. ADDRESS <u>Rock Port, Mo</u>		22c. DATE SIGNED <u>3/17/58</u>

23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)
<u>burial</u>		<u>Mar-16/1958</u>	<u>Greenhill cemetery</u>		<u>Rock Port Mo.</u>
24. FUNERAL DIRECTOR <u>Bestman Funeral Home - Rock Port Mo</u> ADDRESS			25. DATE RECD. BY LOCAL REG. <u>Mar 22, 1958</u>	26. REGISTRAR'S SIGNATURE <u>Marvin H. Schaefer</u>	

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only statements related. All diseases in Part I must be causally related.

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 *W. E. Burton* .....

Licensed Embalmer No. *1764* .....

P. O. Address *Rochester, N.Y.* .....

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.