

FILED APR 28 1958

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-015394

STATE FILE NUMBER

Registration District No. 310 Primary Registration District No. 3058 Registrar's No. 100

300
-57

| | | | |
|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>St. Charles</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Charles</u> <u>admission 0922</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Charles</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Joseph</u> | | Length of stay in lb <u>9 weeks</u> | d. STREET ADDRESS <u>RR #3</u> (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> |

| | | | | | |
|---|--|--|---|--|--|
| 3. NAME OF DECEASED (Type or print) First <u>Oscar</u> Middle _____ Last <u>Earnest</u> | | | 4. DATE OF DEATH Month <u>April</u> Day <u>18</u> Year <u>1958</u> | | |
|---|--|--|---|--|--|

| | | | | | | |
|-----------------------|----------------------------------|---|---|--|---|--|
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</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>Nov. 1, 1882</u> | 9. AGE (In years last birthday) <u>75</u> | IF UNDER 1 YEAR Months <u>5</u> Days <u>17</u> | IF UNDER 24 HRS. Hours _____ Min. _____ |
|-----------------------|----------------------------------|---|---|--|---|--|

| | | | |
|---|--|--|---|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u> | 10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u> | 11. BIRTHPLACE (City and state or country) <u>Fulton, Mo.</u> | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> |
|---|--|--|---|

| | | |
|---|--|--|
| 13a. FATHER'S NAME <u>Miller Earnest</u> | 13b. MOTHER'S MAIDEN NAME <u>Louise Fines</u> | 14. NAME OF HUSBAND OR WIFE <u>Minnie Neumann</u> |
|---|--|--|

| | | | |
|---|---|---|---------------|
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Year, no. or unknown) (If yes, give war or dates of service) <u>No</u> | 16. SOCIAL SECURITY NO. <u>499-03-7253</u> | 17. INFORMANT <u>Mrs. Clarence Twiehaus, Wright City Mo.</u> | Address _____ |
|---|---|---|---------------|

| | | |
|---|--|---|
| 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>Pneumonia</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>7 wk</u> <u>4 wk</u> <u>10 yr</u> |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Cerebral thromboses</u> | | |
| DUE TO (c) <u>Arteriosclerosis Generalized</u> | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Diabetes Mellitus</u> | | 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>332X</u> |
|---|---|

| | | | |
|---|---|--|--|
| 20c. TIME OF INJURY Hour _____ 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 1952</u> to <u>April 18, 1958</u> and last saw her/him alive on <u>April 18, 1958</u> Death occurred at <u>2:30 AM</u> m on the date stated above; and to the best of my knowledge, from the causes stated. |
|--|

| | | |
|--|---------------------------------------|---|
| 22a. SIGNATURE <u>W. H. Baggenave</u> (Degree or title) <u>MD</u> | 22b. ADDRESS <u>St Charles, Mo</u> | 22c. DATE SIGNED <u>April 19, 1958</u> |
|--|---------------------------------------|---|

| | | | |
|---|-----------------------------------|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u> | 23b. DATE <u>Apr. 21, 1958</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Hawk Point Cemetery</u> | 23d. LOCATION (City, town, or county) (State) <u>Hawk Point Mo.</u> |
|---|-----------------------------------|--|--|

| | | | |
|---|-----------------------|---|--|
| 24. FUNERAL DIRECTOR <u>H.C. Dallmeyer & Sons, St. Charles</u> | ADDRESS <u>Mo.</u> | 25. DATE RECD. BY LOCAL REG. <u>APR. 20-58</u> | 26. REGISTRAR'S SIGNATURE <u>Marella Wilson</u> |
|---|-----------------------|---|--|

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

APR 30 1956

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 *Frank R. Amalon*
Licensed Embalmer No. *4837*
P. O. Address *St. Charles*

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.