

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-032270
STATE FILE NUMBER

63265-58
FILED OCT 6 1958

Registration District No. 115-116 Primary Registration District No. 3020 Registrar's No. 241

S. 300
1-57

1. PLACE OF DEATH a. COUNTY Franklin		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE ** b. COUNTY **	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Washington		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN 0362 ** c
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Francis Hosp.		Length of stay in lb **	d. STREET ADDRESS (If outside, give location) **
3. NAME OF DECEASED (Type or print) First Dale Middle Pietraschke Last Pietraschke		4. DATE OF DEATH Month Sept. Day 25 Year 1958	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 25, 1958
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none	9. AGE (In years last birthday) 0 UNDER 1 YEAR Months 0 Days 0 IF UNDER 24 HRS. Hours 4 Min.
11a. BIRTHPLACE (City and state or country) Washington, Mo.		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME Clarence Pietraschke		13b. MOTHER'S MAIDEN NAME Hulda Held	14. NAME OF HUSBAND OR WIFE none
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. none	17. INFORMANT Address Clarence Pietraschke Cuba, Mo. Rt.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Atelectasis, bilateral DUE TO (b) Premature birth DUE TO (c) 7625 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 3 1/2 h.
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 Hour a.m. Month, Day, Year p.m.		20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE 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 25 Sep 58 to 25 Sep 58 and last saw ^{her} him alive on 25 Sep 58 Death occurred at 3:30 P. m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) W. W. Boyce, MD.		22b. ADDRESS Washington, Mo	22c. DATE SIGNED 29 Sep 58
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE Sept. 26, 1958	23c. NAME OF CEMETERY OR CREMATORY St. Johns E & R Cem.	23d. LOCATION (City, town, or county) (State) Rem, Mo.
24. FUNERAL DIRECTOR ADDRESS Michael J. H. Winter OWENSVILLE		25. DATE RECD. BY LOCAL REG. 10/1/58	26. REGISTRAR'S SIGNATURE F. L. J. Hedmann & P. J. Hedmann

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

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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 *Michael J. Winter*

Licensed Embalmer No. *3838*

P. O. Address *OWENS HILL*

NO EMBALMING

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.