

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-044793

STATE FILE NUMBER

FILED DEC 22 1958 Registration District No. 179 Primary Registration District No. 5667 Registrar's No. 211

1. PLACE OF DEATH a. COUNTY Lincoln		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Lincoln	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Troy Missouri		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Old Monroe 0570 Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Troy Hospital		Length of stay in 1b 12 hours	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Frederick Middle Ortlepp Last Ortlepp			4. DATE OF DEATH Month 12 Day 12 Year 1958		
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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 Feb. 17, 1889	9. AGE (In years last birthday) 69	IF UNDER 1 YEAR Months 9 Days 15	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer	10b. KIND OF BUSINESS OR INDUSTRY laborer	11. BIRTHPLACE (City and state or country) St. Louis, Missouri	12. CITIZEN OF WHAT COUNTRY? U. S. A.
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13a. FATHER'S NAME William Ortlepp	13b. MOTHER'S MAIDEN NAME Schroer	14. NAME OF HUSBAND OR WIFE single
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address Mrs. Krueger, Old Monroe, Missouri
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Medullary Paralysis		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Renal Failure & Anemia	
	DUE TO (c) Cardiac Decompensation	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Pneumonia		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.)
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20c. TIME OF INJURY Hour Month Day Year a.m. p.m. 	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
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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
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21. I attended the deceased from **12-11-58** to **12-12-58** and last saw her/him alive on **12-11-58**
Death occurred at **1:45 AM** on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Leonard Barfoot Sr. (Degree or title) Dr.	22b. ADDRESS Troy, Mo	22c. DATE SIGNED 12-14-58
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23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE Dec. 14, 1958	23c. NAME OF CEMETERY OR CREMATORY St. Paul Cemetery	23d. LOCATION (City, town, or county) (State) Old Monroe, Missouri
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24. FUNERAL DIRECTOR E. A. Keithly	ADDRESS O'Fallon, Mo.	25. DATE RECD. BY LOCAL REG. Dec. 19, 1958	26. REGISTRAR'S SIGNATURE Charlotte Leek
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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DEC 28 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 *E. Keithly*

Licensed Embalmer No. *827*

P. O. Address *W. J. Fallon M.*

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.