

Health,  
Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-004614

STATE FILE NUMBER

160

FILED FEB 16 1959

Registration District No. 042

Primary Registration District No. 1000

Registrar's No.

300  
-57

1. PLACE OF DEATH a. COUNTY <b>Buchanan</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Buchanan</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Joseph</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>St. Joseph</b> <b>0117</b> <b>0</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>2410 Mary</b>		Length of stay in lb <b>11 years</b>	d. STREET ADDRESS (If outside, give location) <b>2410 Mary</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>OTTO</b> Middle <b>ROMMEL</b> Last <b>ROMMEL</b>			4. DATE OF DEATH Month <b>Feb.</b> Day <b>4,</b> Year <b>1959</b>		
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 6, 1878</b>	9. AGE (In years last birthday) <b>80</b>	IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. Painter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Automobile Co.</b>	11. BIRTHPLACE (City and state or country) <b>St. Joseph, Mo.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13a. FATHER'S NAME <b>Charles Rommel</b>		13b. MOTHER'S MAIDEN NAME <b>Anna Kirstein</b>		14. NAME OF HUSBAND OR WIFE <b>_____</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>unknown</b>		17. INFORMANT <b>Mrs. Tillie Goodwin, 2410 Mary, St. Joseph, Mo.</b> Address <b>_____</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arterio sclerosis (myocardial insufficiency)</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Hypertensive arterio sclerotic cardiovascular renal disease</b> DUE TO (c) <b>Senility</b>					INTERVAL BETWEEN ONSET AND DEATH <b>442X</b>
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 <b>_____</b> Month <b>_____</b> Day <b>_____</b> Year <b>_____</b> a.m. <b>_____</b> p.m. <b>_____</b>			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 <b>12-23-58</b> to <b>2-4-59</b> and last saw her alive on <b>2-3-59</b> Death occurred at <b>6:30p.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <b>Dr. C.S. Grant</b> (Degree or title)			22b. ADDRESS <b>St. Joseph, Mo</b>		22c. DATE SIGNED <b>2.6.59</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE <b>2/6/1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Ashland Cemetery</b>		23d. LOCATION (City, town, or country) (State) <b>St. Joseph Mo.</b>
24. FUNERAL DIRECTOR <b>Wheaton - Bowman</b>		ADDRESS <b>St. Joseph, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>Feb. 11, 1959</b>		26. REGISTRAR'S SIGNATURE <b>Mrs. Clark Goodell</b>

MEDICAL CERTIFICATION

Dr. C.S. Grant  
US ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

1300  
1900

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 *John W. Herrick* .....  
Licensed Embalmer No. *1848* .....  
P. O. Address *S. C. Ind.* .....

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.