

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-006780
State File No.

FILED MAR 16 1959

BIRTH MO. _____		REG. DIST. NO. <u>310</u>		PRIMARY REG. DIST. NO. <u>6051</u>		Registrar's No. <u>67</u>	
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>FRANKLIN</u>			
b. CITY (If outside corporate limits, write RURAL and give town or township) <u>ST. CHARLES RURAL</u>		c. LENGTH OF STAY (in this place) <u>2 YEARS</u>		c. CITY OR TOWN <u>WASHINGTON</u>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>EVANGELICAL EMMAUS HOME</u>				e. STREET ADDRESS (If rural, give location) _____			
3. NAME OF DECEASED (Type or Print) a. (First) <u>ROSA</u>			b. (Middle) <u>-</u>			c. (Last) <u>DANKENBRING</u>	
4. DATE OF DEATH (Month) (Day) (Year) <u>MARCH 11, 1959</u>							
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>APRIL 24, 1874</u>		9. AGE (In years last birthday) <u>84</u>		IF UNDER 1 YEAR Months Days
IF UNDER 1 YEAR Hours Min.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MILLINER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MILLINER</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>MISSOURI</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13a. FATHER'S NAME <u>HENRY H. THIAS</u>			13b. MOTHER'S MAIDEN NAME <u>WILHELMINA TODT</u>			14. NAME OF HUSBAND OR WIFE <u>WILL DANKENBRING</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Theophil Staercken ST. CHARLES, MO.</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Pneumonia</u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 day</u>	
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Arteriosclerotic Heart Disease</u>					
		DUE TO (c) _____					
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? <u>Yes</u> <input checked="" type="checkbox"/> <u>No</u> <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>4200</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____			
22. I hereby certify that I attended the deceased from <u>Sept 1958</u> , to <u>March 1959</u> , that I last saw the deceased alive on <u>March 1, 1959</u> , and that death occurred at <u>5:00 A.M.</u> , from the causes and on the date stated above.							
23. SIGNATURE <u>W.H. Poggemeier M.D.</u>				23b. ADDRESS <u>St. Charles Mo</u>		23c. DATE SIGNED <u>March 11, 1959</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>March 14 1959</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Odd Fellows</u>		24d. LOCATION (City, town, or county) (State) <u>Washington, Mo.</u>	
DATE REC'D BY LOCAL REG. <u>MAR 11-59</u>		REGISTRAR'S SIGNATURE <u>Marcella Wilson</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Nieburg & Vitt Washington, Mo.</u>			

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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..... *Lester A. Witt*

Licensed Embalmer No. *325*.....

P. O. Address *Washington*.....

**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.**