

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-012177

STATE FILE NUMBER

FILED APR 27 1959

Registration District No. 002

Primary Registration District No. 5015

Registrar's No. 26

300  
1-57

1. PLACE OF DEATH a. COUNTY <b>Andrew</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence for admission) a. STATE <b>Missouri</b> b. COUNTY <b>Andrew</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Rural:Lincoln Twp.</b>		c. CITY OR TOWN <b>Savannah</b> <span style="float:right">0020 0</span>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>R. R. #2</b>		d. STREET ADDRESS (If outside, give location) <b>R. R. #2</b>	
Length of stay in lb <b>most of life</b>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <b>GOTTFRIED</b> Middle <b>JOHN</b> Last <b>DALLENBACH</b>	4. DATE OF DEATH Month <b>April</b> Day <b>16</b> Year <b>1959</b>
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5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 28, 1874</b>	9. AGE (In years last birthday) <b>84</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
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10a. MAJOR OCCUPATION (Give kind of work done during most of working life, even if retired) <b>farmer</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>farm</b>	11. BIRTHPLACE (City and state or country) <b>Bern Switzerland</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
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13a. FATHER'S NAME <b>John Dallenbach</b>	13b. MOTHER'S MAIDEN NAME <b>unknown</b>	14. NAME OF HUSBAND OR WIFE <b>Lou</b>
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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) <b>no</b>	16. SOCIAL SECURITY NO. <b>none</b>	17. INFORMANT <b>Mrs. G. J. Dallenbach, R. R. #2, Savannah, Mo.</b>	Address
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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) <b>Chronic Endocarditis</b>	INTERVAL BETWEEN ONSET AND DEATH <b>2 years</b>
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Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b) \_\_\_\_\_  
DUE TO (c) **Arteriosclerosis Nephritis**

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)  
**Arteriosclerosis Nephritis**

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <b>2</b>
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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 _____ a.m. _____ p.m. _____	20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20e. 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 <b>December 25, 1958</b> to <b>April 16, 1959</b> and last saw him alive on <b>April 16, 1959</b> Death occurred at <b>4:00 p.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE (Degree or title) <b>Neva M. Steadley</b>	22b. ADDRESS <b>801 1/2 Francis, St. Joseph, Mo.</b>	22c. DATE SIGNED <b>Mo. April 15, 1959</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	23b. DATE <b>4/19/1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. Johns Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Amazonia Missouri</b>
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24. FUNERAL DIRECTOR <b>Heater Bowman</b>	ADDRESS <b>St. Joseph, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>4-21-59</b>	26. REGISTRAR'S SIGNATURE <b>William Sparks-Roy</b>
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All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

*Handwritten notes in the top right corner, possibly including a name and a date.*

SEPT 28 1963

OCT 21 1963

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 *William Spaulding* .....

Licensed Embalmer No. *4535* .....

P. O. Address *Joseph ...*

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.