

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-017497

STATE FILE NUMBER

DECEASED JUN 8 1959

Registration District No. 137 Primary Registration District No. 3023 Registrar's No. 143

300
1-57

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY <u>Henry</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Bates</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Clinton Mo</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Rockville Mo.</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Wetzel Hosp.</u> Length of stay in 1b <u>1 day</u>		d. STREET (If outside, give location) ADDRESS <u>Rockville 2up.</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Herman</u> Middle <u>J</u> Last <u>INDENMAN</u>		4. DATE OF DEATH Month <u>June</u> Day <u>2</u> Year <u>59</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 24-1917</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer.</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <u>42</u> IF UNDER 1 YEAR: Months <u>3</u> Days <u>4</u> IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
11. BIRTHPLACE (City and state or country) <u>Pleasant Gap, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>ROBERT JINDENMAN</u>		13b. MOTHER'S MAIDEN NAME <u>BERTHA MAUGH ANNA JINDENMAN</u>	
14. NAME OF HUSBAND OR WIFE <u>ANNA JINDENMAN</u>		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. <u>495-42-612</u>		17. INFORMANT <u>Anna Jindeman, Rockville Mo</u> Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Medullary Paralysis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Cerebro-vascular thrombosis</u> DUE TO (c) <u>Gen. Atherosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition in PART I (a) <u>Uremia due to chronic nephritis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>Hrs</u> <u>?</u> <u>?</u>
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 <u></u> Month, Day, Year <u></u> a.m. <u></u> p.m. <u></u>		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 <u>6-1-59</u> to <u>6-2-59</u> and last saw <u>him</u> alive on <u>6-2-59</u> Death occurred at <u>12:15</u> <u>a</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Arturo Gonzalez DO</u>		22b. ADDRESS <u>717 E Jefferson St Clinton</u>	22c. DATE SIGNED <u>6-2-59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>6-4-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Reformed</u>	23d. LOCATION (City, town, or county) (State) <u>PAIRIE CITY MO.</u>
24. FUNERAL DIRECTOR <u>Oscar Eddy of Clinton City Mo</u> ADDRESS		25. DATE RECD. BY LOCAL REG. <u>6-2-59</u>	26. REGISTRAR'S SIGNATURE <u>Mildred Biggers</u>

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 *Oscar Eckhoff*

Licensed Embalmer No. *3942*

P. O. Address *Appleton, Wis.*

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.