

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-029854

FILED VS SEP 15 1959

Registration District No. 231 Primary Registration District No. 4346 Registrar's No. 45 STATE FILE NUMBER C

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Montgomery</b>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Montgomery City</b>		Length of stay in 1b		c. CITY OR TOWN <b>Montgomery City</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			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		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 <b>Julia</b> Middle <b>Elizabeth</b> Last <b>Oliver</b>				4. DATE OF DEATH Month <b>September</b> Day <b>6</b> Year <b>1959</b>				
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>3-27-1879</b>	9. AGE (last birthday) <b>80</b>	IF UNDER 1 YEAR Months <b>5</b> Days	IF UNDER 24 HR Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	11. BIRTHPLACE (City and state or country) <b>Montgomery City, Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>		
13a. FATHER'S NAME <b>Herman Willi</b>			13b. MOTHER'S MAIDEN NAME <b>Sophia Schwendker</b>		14. NAME OF HUSBAND OR WIFE <b>None</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>None</b>	17. INFORMANT <b>Miss Elizabeth Oliver</b> Address <b>Montgomery City, Missouri</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>ACUTE MYOCARDIAL FAILURE</b> DUE TO (b) <b>CEREBRAL ACCIDENT</b> DUE TO (c) <b>ARTERIO-SCLEROSIS</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <b>3 1/2</b> <b>7 1/2</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
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.)						
20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year							
20d. INJURY OCCURRED WHILE AT WORK <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>Jan-15-1954</b> to <b>Sept. 6, 1959</b> and last saw her alive on <b>Sept 5, 1957</b> Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <b>James O. Helm MD</b> (Degree or title)				22b. ADDRESS <b>New Florence Mo.</b>		22c. DATE SIGNED <b>9-8-59</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county)		(State)		
<b>Burial</b>	<b>Sept. 8, 1959</b>	<b>Montgomery Cemetery</b>		<b>Montgomery City, Missouri</b>				
24. FUNERAL DIRECTOR <b>Schlanker Funeral Home</b> ADDRESS <b>Montgomery City, Missouri</b>			25. DATE RECD. BY LOCAL REG. <b>9-8-1959</b>	26. REGISTRAR'S SIGNATURE <b>Laura B. Callaway</b>				

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by

or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed

*E. Boone Schlan*

Licensed Embalmer No. 4136

P. O. Address Montgomery

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.