

IRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-031708

FILED VS SEP 22 1959 53

Registration District No. _____ Primary Registration District No. 3009 Registrar's No. 323

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Cape Girardeau</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Cape Girardeau</u>									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>JACKSON</u>		Length of stay in 1b <u>14 Months</u>		c. CITY OR TOWN <u>JACKSON</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Deal Nursing Home</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>208 So. Russell</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <u>Jacob</u> Middle <u>William</u> Last <u>Fikuart</u>				4. DATE OF DEATH Month <u>Sept.</u> Day <u>14</u> Year <u>1959</u>									
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>11/4/1873</u>		9. AGE (last birthday) <u>85</u>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HR Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Miller</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Milling Indu.</u>			11. BIRTHPLACE (City and state or country) <u>Sedgewickville, Mo.</u>			12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>				
13a. FATHER'S NAME <u>Henry Fikuart</u>				13b. MOTHER'S MAIDEN NAME <u>Seabaugh</u>				14. NAME OF HUSBAND OR WIFE <u>Deceased</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>				17. INFORMANT <u>Mae Keisker Jackson, 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>Arteriosclerotic Heart Disease</u>										INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u>			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____													
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 <u>6-10-58</u> to <u>9-14-59</u> and last saw him alive on <u>Sept. 12, 1959</u> Death occurred at <u>8:30</u> <u>A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE <u>J. N. Jarger, M.D.</u> (Degree or title)						22b. ADDRESS <u>Jackson, Mo.</u>				22c. DATE SIGNED <u>Sept 14, 1959</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <u>9/16/1959</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rose Lawn</u>				23d. LOCATION (City, town, or county) (State) <u>Crystal City Mo.</u>					
24. FUNERAL DIRECTOR <u>McCombs Jackson, Mo.</u> ADDRESS _____				25. DATE RECD. BY LOCAL REG. <u>9-14-1959</u>		26. REGISTRAR'S SIGNATURE <u>Green Kasten</u>							

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 B A Meyer

Licensed Embalmer No. 3051

R. O. Address Jackson

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.