

R DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-031924

FILED VS OCT 13 1959

Registration District No. 115-116 Primary Registration District No. 3020 Registrar's No. 215

STATE FILE NUMBER

DED

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
a. COUNTY FRANKLIN				a. STATE MO.		b. COUNTY FRANKLIN	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN WASHINGTON			Length of stay in 1b —	c. CITY OR TOWN UNION		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. FRANCIS HOSP.			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 408 CHRISTINA AVE.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH		5. MONTH DAY YEAR	
First JOHN		Middle		Last MONZYK		OCT. 7 1959	
5. SEX MALE	6. COLOR OR RACE WHITE	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH OCT. 7, 1959	9. AGE (last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HR
						Months	Days
						Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none			10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (City and state or country) WASHINGTON, MO.		12. CITIZEN OF WHAT COUNTRY U.S.A
13a. FATHER'S NAME WILLIAM MONZYK			13b. MOTHER'S MAIDEN NAME ANN MURPHY			14. NAME OF HUSBAND OR WIFE NONE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT WILLIAM MONZYK		Address UNION, MO.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) Respiratory failure.						10 min.	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						DUE TO (b) Cerebral failure.	
						DUE TO (c) Congenital malformation	
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 Oct 7 to Oct 7 and last saw ^{her} _{him} live on Oct 7 Death occurred at 2 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) George E. Richardson, M.D.				22b. ADDRESS Union, Mo.		22c. DATE SIGNED Oct 9, 1959	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE OCT. 8, 1959	23c. NAME OF CEMETERY OR CREMATORY IMMACULATE CONCEPTION		23d. LOCATION (City, town, or county) UNION, MO		(State)	
24. FUNERAL DIRECTOR ADDRESS OLTMANN FUNERAL HOME UNION, MO.				25. DATE RECD. BY LOCAL REG. 10/8/59		26. REGISTRAR'S SIGNATURE J. H. Hedmann & J. H. Hedmann	

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 _____, Student Embalmer No. _____
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed *Not Em*
Ralph Oltmann

Licensed Embalmer No. *4808*

P. O. Address *Union N*

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.