

**FURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

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FILED VS DEC 3 0 1959 275

Primary Registration District No. 3053

Registrar's No. 245

STATE FILE NUMBER

INDEXED

|  |  |   |  |   |   |  |   |
|--|--|---|--|---|---|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Phelps</b>   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>MISSOURI</b> COUNTY <b>OSAGE</b> |   |  |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>Rolla</b>  |  | Length of stay in 1b<br><b>1 year</b>   |  | c. CITY OR TOWN <b>WESTPHALIA, MO.</b>  |   | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>   |   |
| c. FULL NAME OF (IF NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>McFarland Nursing Home</b>   |  |   | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location)<br><b>None</b>  |   |  | Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED<br>(Type or print) First Middle Last<br><b>JOSEPHINE TEMMEN</b>  |  |   |  | 4. DATE OF DEATH<br>Month Day Year<br><b>DEC. 18, 1959</b>  |   |  |   |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b>       | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>3/13/68</b>  | 9. AGE (last birthday)<br><b>91</b>                             | IF UNDER 1 YEAR<br>Months Days   | IF UNDER 24 HR<br>Hours Min.  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>HOUSEWIFE</b>  |  |   | 10b. KIND OF BUSINESS OR INDUSTRY  | 11. BIRTHPLACE (City and state or country)<br><b>WESTPHALIA, MO.</b>  |   | 12. CITIZEN OF WHAT COUNTRY<br><b>USA</b>  |   |
| 13a. FATHER'S NAME<br><b>JOHN BRESTER</b>  |  |   | 13b. MOTHER'S MAIDEN NAME<br><b>UNKNOWN</b>  |   | 14. NAME OF HUSBAND OR WIFE<br><b>JOSEPH TEMMEN</b>             |  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give war or dates of service)<br><b>NO</b>   |  | 16. SOCIAL SECURITY NO.<br><b>NONE</b>  | 17. INFORMANT<br>Address<br><b>CLEM TEMMEN J C MO.</b>                               |   |   |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b>   |  |   |  |   |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>7 days</b>                                     |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.)<br>DUE TO (b) _____<br>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.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |   |
| 19. WAS AUTOPSY PERFORMED?<br>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<br>Hour a.m. p.m.  |  | Month, Day, Year  |  |   |   |  |   |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/><br>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>11-14-59</b> to <b>12-18-59</b> and last saw her/him alive on <b>12-16-59</b><br>Death occurred at <b>9:30 A.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated. |  |   |  |   |   |  |   |
| 22a. SIGNATURE<br><b>James M. Myers</b> (Degree or title) <b>MD</b>  |  |   |  | 22b. ADDRESS<br><b>Rolla Mo</b>   |   |  | 22c. DATE SIGNED<br><b>12/22/59</b>   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>12/21/59</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>St. Joseph</b>                              |   | 23d. LOCATION (City, town, or county)<br><b>Westphalia, Mo.</b> |  | (State)   |
| 24. FUNERAL DIRECTOR<br><b>Lybister Dulle</b> ADDRESS<br><b>J C MO.</b>  |  |   | 25. DATE RECD. BY LOCAL REG.<br><b>Dec. 23, 1959</b>                                 |   | 26. REGISTRAR'S SIGNATURE<br><b>Nadene L. Stoll</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 me  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Paul E. Null

Licensed Embalmer No. 4498

P. O. Address Rolla, Mo

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.