

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS JAN 22 1960

-60-000055

Registration District No. 10 Primary Registration District No. 3002 Registrar's No. 8

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Audrain</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> COUNTY <u>Audrain</u>									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Mexico</u>		Length of stay in 1b <u>1 day</u>		c. CITY OR TOWN <u>RR #1 Laddonia</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>Audrain Hospital</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>Linn township</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>BERNARD</u> Last <u>FENNEWALD</u>				4. DATE OF DEATH Month <u>Jan.</u> Day <u>8</u> Year <u>1960</u>									
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</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>Aug. 13 1881</u>		9. AGE (last birthday) <u>78</u>		IF UNDER 1 YEAR Months <u>4</u> Days <u>25</u>		IF UNDER 24 HR Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>general farming</u>		11. BIRTHPLACE (City and state or country) <u>Westphalia, Mo</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>					
13a. FATHER'S NAME <u>Adolph B. Fennwald</u>				13b. MOTHER'S MAIDEN NAME <u>Clara M. Bertels</u>				14. NAME OF HUSBAND OR WIFE <u>Clara M. Bertels</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>?</u>		17. INFORMANT Address <u>Anthony Becker, Laddonia, Mo</u>							
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) <u>Acute Posterior Myocardial Infarction</u>										<u>48 hours</u>			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Coronary arteriosclerosis</u>										<u>years</u>			
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>Jan 7 60</u> to <u>Jan 8 - 60</u> and last saw ^{her} him alive on <u>Jan 8 - 60 -</u> Death occurred at <u>9:45 A.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE (Degree or title) <u>Harold Langford M.D.</u>						22b. ADDRESS <u>Imperial Mo</u>			22c. DATE SIGNED <u>1-15-60</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>Jan. 11, 1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Joseph</u>			23d. LOCATION (City, town, or county) <u>Martinsburg, Mo</u>						
24. FUNERAL DIRECTOR <u>K. B. Wells, Wellsville, Mo</u>					25. DATE RECD. BY LOCAL REG. <u>Jan 11 - 1960</u>		26. REGISTRAR'S SIGNATURE <u>Blanche Reely</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 Howard F Myers

Licensed Embalmer No. 4494

P. O. Address Wellsville, M

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.