

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

**-60-007452**

**FILED VS MAR 3 1960**

**264**

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>Ozark</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>Ozark</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Jasper twp.</b>		Length of stay in 1b <b>10 Months</b>		c. CITY OR TOWN <b>Isabella</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>Jasper twp.</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Mollie</b> Middle <b>Enochs</b> Last				4. DATE OF DEATH Month <b>2</b> Day <b>29</b> Year <b>1960</b>			
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</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>9-13-1880</b>	9. AGE (last birthday) <b>79</b>	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) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own</b>		11. BIRTHPLACE (City and state or country) <b>St. Louis, Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>Rudolph Moellman</b>			13b. MOTHER'S MAIDEN NAME <b>Amalia</b>		14. NAME OF HUSBAND OR WIFE <b>Otto H. Enoch</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>494-01-0430 D</b>	17. INFORMANT <b>Mollie Lehnhoff Isabella, Mo</b> 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) <b>Bronchial pneumonia</b>						INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.) DUE TO (b) <b>Epidemic influenza</b>						<b>1 week</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 <b>2/28/60</b> to <b>2/29/60</b> and last saw her <sup>her</sup> alive on <b>2/28/60</b> Death occurred at <b>3:00</b> <b>A</b> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <b>M. J. Hoerman DD</b>			22b. ADDRESS <b>Gainesville, Mo.</b>			22c. DATE SIGNED <b>3/1/60</b> <b>3/1/60</b> (Date)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>2-29-60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Oak Grove</b>		23d. LOCATION (City, town, or county) <b>Maplewood, Mo.</b>			
24. FUNERAL DIRECTOR <b>Clinkingbeard</b> ADDRESS <b>Gainesville, Mo</b>			25. DATE RECD. BY LOCAL REG. <b>3-1-60</b>		26. REGISTRAR'S SIGNATURE <b>Shana Mahan</b>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

1961

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 John R. Vasey

Licensed Embalmer No. 4885

P. O. Address Summit

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.