

# RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS. APR 14 1960 75

60-010322  
STATE FILE NUMBER

Primary Registration District No. 3045 Registrar's No. 38

DEED

1. PLACE OF DEATH a. COUNTY <b>Clinton</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Daviess</b>															
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Cameron</b>		Length of stay in 1b <b>5 Days</b>		c. CITY OR TOWN <b>Gallatin</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>													
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Cameron Community Hosp</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>---</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>												
3. NAME OF DECEASED (Type or print) First <b>Christie</b> Middle <b>B.</b> Last <b>Fossinger</b>				4. DATE OF DEATH Month <b>March</b> Day <b>30</b> Year <b>1960</b>															
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>8-29-1890</b>		9. AGE (last birthday) <b>69</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HR Hours Min.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Farm Owner</b>			11. BIRTHPLACE (City and state or country) <b>Daviess Co. Mo.</b>			12. CITIZEN OF WHAT COUNTRY <b>USA</b>										
13a. FATHER'S NAME <b>Emanuel Fossinger</b>				13b. MOTHER'S MAIDEN NAME <b>Sarah Ginder</b>				14. NAME OF HUSBAND OR WIFE <b>Jennie Fossinger</b>											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>				16. SOCIAL SECURITY NO. <b>496-42-1513</b>		17. INFORMANT Address <b>Mrs. Jennie Fossinger, Gallatin, Mo.</b>													
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>Coronary Occlusion</b> DUE TO (b) <b>Arteriosclerosis</b> DUE TO (c) <b>5 yrs</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.										INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs</b> <b>5 yrs</b>									
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 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>Mar 30, 1960</b> to <b>Mar 30</b> and last saw him alive on <b>Mar 30, 60</b> Death occurred at <b>9:30 P.m.</b> on the date stated above, and to the best of my knowledge, from the causes stated.																			
22a. SIGNATURE <b>Floyd E. Nelson M.D.</b> (Doctor or title)				22b. ADDRESS <b>Gallatin, Mo.</b>				22c. DATE SIGNED <b>4-1-60</b>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>4-1-1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Civil Bend Christian</b>				23d. LOCATION (City, town, or county) (State) <b>Daviess Co. Mo.</b>											
24. GENERAL DIRECTOR'S ADDRESS <b>Hope Funeral Home, Gallatin, Mo.</b>				25. DATE RECD. BY LOCAL REG. <b>4-5-68</b>		26. REGISTRAR'S SIGNATURE <b>Frances D Crawford</b>													

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

OCT 4 1962

**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 *L. P. Dickerson*

Licensed Embalmer No. 3302

P. O. Address Dullata

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.