

JURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-015813

FILED VS. MAY 5 1960

157

Primary Registration District No.

3028

Registrar's No.

97

STATE FILE NUMBER

UNRECORDED

| | | | | | | | | | | | |
|--|--------------------------------------|--|--|---|--|--|--|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Jasper</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Carthage Mo</u> Length of stay in 1b <u>3 Da</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>M - Cune Hosp</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Jasper</u> c. CITY OR TOWN <u>Sarsawie</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>Mo</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Anna M Fieker</u> | | | 4. DATE OF DEATH Month Day Year <u>April 24-60</u> | | | | | | | | |
| 5. SEX <u>fe</u> | 6. COLOR OR RACE <u>wh</u> | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>4/4/84</u> | 9. AGE (last birthday) <u>76</u> | 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) <u>House wife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u></u> | | 11. BIRTHPLACE (City and state or country) <u>Illinois</u> | | 12. CITIZEN OF WHAT COUNTRY <u>USA</u> | | | | | |
| 13a. FATHER'S NAME <u>Fred Attmeyer</u> | | 13b. MOTHER'S MAIDEN NAME <u>Sophia Heppmeyer</u> | | 14. NAME OF HUSBAND OR WIFE <u>deceased</u> | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <input checked="" type="checkbox"/> | | 16. SOCIAL SECURITY NO. <u>none</u> | | 17. INFORMANT Address <u>James Fieker Sarsawie Mo</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion with</u> (b) <u>Myocardial infarction</u> (c) <u>Coronary sclerosis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>5 Days</u> <u>unknown</u> | | | |
| 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 Month, Day, Year a.m. p.m. | | 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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>1-29-57</u> to <u>24 April 1960</u> and last saw her/him alive on <u>24 April 1960</u> . Death occurred at <u>April 24-60 at 6:30 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>W. M. Jones M.D.</u> | | | | 22b. ADDRESS <u>1515 Ford Carthage Mo 62860</u> | | 22c. DATE SIGNED <u>4-28-60</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE <u>4/26/60</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Zion Cem</u> | | 23d. LOCATION (City, town, or county) (State) <u>Stotts City Mo</u> | | | | | |
| 24. FUNERAL DIRECTOR <u>Jackson & Sons</u> ADDRESS <u>Sarsawie Mo</u> | | 25. DATE RECD. BY LOCAL REG. <u>4-28-60</u> | | 26. REGISTRAR'S SIGNATURE <u>Edw. Clinton</u> | | | | | | | |

(Licensed Embalmer's Statement on Reverse Side)

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 Wm H. Jackson

Licensed Embalmer No. 3954

P. O. Address Sarasota

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.