

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-034071

FILED VS. OCT 3 1960

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Registration District No. 3010 Registrar's No. 388

STATE FILE NUMBER

INDEXED

1. PLACE OF DEATH a. COUNTY <b>Cape Girardeau</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> COUNTY <b>Cape</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Cape Girardeau</b>		Length of stay in 1b <b>40 yr</b>		c. CITY OR TOWN <b>Cape Girardeau</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Southeast Hospital</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>14 N Henderson</b>	
3. NAME OF DECEASED (Type or print) First <b>Otto</b> Middle <b>Emil</b> Last <b>Eggimann</b>			4. DATE OF DEATH Month <b>Sept</b> Day <b>27</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>7-28-1881</b>	9. AGE (last birthday) <b>79</b>	IF UNDER 1 YEAR Months <b>1</b> Days <b>29</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Feed Store Operator</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Dutchtown Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A</b>	
13a. FATHER'S NAME <b>Jacob Eggimann</b>		13b. MOTHER'S MAIDEN NAME <b>Mathilda Engemann</b>		14. NAME OF HUSBAND OR WIFE <b>Mathilda Eggimann</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>UNKNOWN</b>		17. INFORMANT <b>Mrs Ted Suedekum, Cape Gir 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>Bronchial Pneumonia</b>					INTERVAL BETWEEN ONSET AND DEATH <b>5 days.</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (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) <b>macrocytic Anemia</b>				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>Sept 22, 1960</b> to <b>Sept 27, 60</b> and last saw <sup>her</sup> <b>him</b> alive on <b>Sept 27, 1960</b> Death occurred at <b>14 Am</b> on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <b>Charles F. Berlin MD</b> (Deedee or title)			22b. ADDRESS <b>Cape Girardeau Mo</b>		22c. DATE SIGNED <b>9/28/60</b> (state)
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>9-29-1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Memorial Park</b>	
23d. LOCATION (City, town, or county) <b>Cape Girardeau Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>10-1-60</b>		26. REGISTRAR'S SIGNATURE <b>Gene Kasten</b>	
24. FUNERAL DIRECTOR <b>Brinkopf Howell, Cape Gir Mo.</b> ADDRESS					

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

\* MAR 22 1963  
 MAR 23 1963

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 W. H. Ester  
 Licensed Embalmer No. 3568  
 P. O. Address Rayville

**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 W. H. Ester  
 Licensed Embalmer No. 3568  
 P. O. Address Rayville

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.