

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-041021

FILED VS NOV 28 1960

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3006

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STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

1. PLACE OF DEATH a. COUNTY <u>Boone</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>FRANKLIN</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Columbia</u>		Length of stay in lb <u>8 days</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>University Hospital</u>		d. STREET ADDRESS (If outside, give location) <u>RT # 2.</u>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last <u>John Otto Dobsch</u>			4. DATE OF DEATH Month Day Year <u>11 23 1960</u>			
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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>11-9-07</u>	9. AGE (last birthday) <u>53</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SHOE FACTORY WORKER</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>WRIGHT CITY, MO.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
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13a. FATHER'S NAME <u>AUGUST Dobsch</u>	13b. MOTHER'S MAIDEN NAME <u>Amelia STRACK</u>	14. NAME OF HUSBAND OR WIFE <u>Edith Dobsch</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no of unknown) (If yes, give war or dates of service) <u>No.</u>	16. SOCIAL SECURITY NO. <u>497-03-2599</u>	17. INFORMANT Address <u>UNIVERSITY HOSPITAL, Columbia MO</u> <u>RECORDS</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>Congestive Failure</u>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Calcific Mitral Valve Stenosis</u>	
	DUE TO (c) <u>Rheumatic Heart Disease</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 checked="" 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.)
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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
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21. I attended the deceased from 11-15-60 to 11-23-60 and last saw him alive on 11-23-60
 Death occurred at 2:30 7 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Morris Gordon MD</u>	22b. ADDRESS <u>Univ. Hosp Columbia, Mo</u>	22c. DATE SIGNED <u>11-23-60</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Funeral</u>	23b. DATE <u>23 Nov 60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Fulton</u>	23d. LOCATION (City, town, or county) (State) <u>Mo.</u>
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24. FUNERAL DIRECTOR ADDRESS <u>Wallace Fulton 460</u>	25. DATE RECD. BY LOCAL REG. <u>Nov. 23, 1960</u>	26. REGISTRAR'S SIGNATURE <u>Mrs. R.E. Palmer</u>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

DEC 8 1960

JAN 6 1961

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

J. R. Masure

Licensed Embalmer No. 499

P. O. Address Fulton, Ga.

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.