

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-009462

STATE FILE NUMBER

Registration District No. 162 Primary Registration District No. 5594 Registrar's No. 27

FILED MAR 24 1961

1. PLACE OF DEATH a. COUNTY <u>JEFFERSON</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Jeff.</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>RURAL MERAMEE</u>		c. CITY OR TOWN <u>CEEDAR HILL</u>	Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>GRAVOIS RD.</u>		d. STREET ADDRESS (If outside, give location) <u>R.R. #1</u>	Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>GOTTLOB</u> Middle <u>W.</u> Last <u>DOLDE</u>			4. DATE OF DEATH Month <u>3</u> Day <u>9</u> Year <u>61</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</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>Oct 29 1895</u>	9. AGE (last birthday) <u>75</u>	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARMING</u>	11. BIRTHPLACE (City and state or country) <u>CELEWISSA MO</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Daniel Dolde</u>		13b. MOTHER'S MAIDEN NAME <u>Charlotte Kiechner</u>		14. NAME OF HUSBAND OR WIFE <u>Anna</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>	17. INFORMANT Address <u>Anna Dolde Cedar Hill Mo</u>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c): PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH <u>30 Min</u>
IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u>		
DUE TO (b) <u>Coronary Thrombosis</u>		
DUE TO (c) _____		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Atypical Pneumonia, Bronchial Asthma</u>		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	
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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
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21. I attended the deceased from Feb. - 10 - 1961 to March - 7 - 61 and last saw ^{him} him alive on March - 7 - 61
Death occurred at 10:30 A m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Jay A Kilpatrick DO</u>	22b. ADDRESS <u>House Springs, Mo</u>	22c. DATE SIGNED <u>3/10/61</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>3/12/61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>ST Martins Cem.</u>	23d. LOCATION (City, town, or county) (State) <u>Dittmer Mo</u>
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24. FUNERAL DIRECTOR <u>BRIMMER Funeral Home</u>	ADDRESS <u>House Springs Mo</u>	25. DATE RECD. BY LOCAL REG. <u>3-12-61</u>	26. REGISTRAR'S SIGNATURE <u>Robert E. Bauer</u>
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DATE PREPARED

INITIAL OF

SHOULD READ

FILE NO.

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 me,
or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Robert J. Gouge

Licensed Embalmer No. 4800

P. O. Address Kirkwood 22

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.