

**MOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

-61-020797  
STATE FILE NUMBER

AMENDED

Registration District No. 93 Primary Registration District No. \_\_\_\_\_ Registrar's No. 61-43

**FILED JUN 13 1961**

1. PLACE OF DEATH a. COUNTY <u>Dade</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Dade</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Lockwood Mo</u>		c. CITY OR TOWN <u>Lockwood Mo</u>	
Length of stay in 1b <u>5wks</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>Memorial Hospital</u>		d. STREET ADDRESS (If outside, give location) <u>lmi north</u>	
Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>Carolina</u> Last <u>Wilhelmina Vonstroh</u>			4. DATE OF DEATH Month <u>May</u> Day <u>27</u> Year <u>1961</u>		
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</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>Nov 2 1868</u>	9. AGE (last birthday) <u>92</u>	IF UNDER 1 YEAR Months <u>6</u> Days <u>25</u>	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>House Wife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	11. BIRTHPLACE (City and state or country) <u>New Minden Ill</u>	12. CITIZEN OF WHAT COUNTRY <u>usa</u>
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13a. FATHER'S NAME <u>Fred Preist</u>	13b. MOTHER'S MAIDEN NAME <u>Fredricks Maschoff</u>	14. NAME OF HUSBAND OR WIFE <u>Henry Vonstroh</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)   (If yes, give war or dates of service) <u>no</u>	16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT <u>Albert Vonstroh Lockwood Mo rt</u>	Address _____
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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
IMMEDIATE CAUSE (a) <u>CHF</u>		<u>3 weeks</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>generalized arteriosclerosis and</u>	<u>years</u>
	DUE TO (c) <u>ASHD</u>	<u>years</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 checked="" 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.)
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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 _____

21. I attended the deceased from 5-6-61 to 5-27-61 and last saw <sup>her</sup> <sub>him</sub> alive on 5-26-61  
Death occurred at 1:30A m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Jerry L Kinder, M.D.</u>	22b. ADDRESS <u>Lockwood, Mo.</u>	22c. DATE SIGNED <u>5-29-61</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>May 29 1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Lutheran</u>	23d. LOCATION (City, town, or county) (State) <u>Lockwood Mo</u>
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24. FUNERAL DIRECTOR <u>Allison Funeral Home Greenfield Mo.</u>	ADDRESS _____	25. DATE RECD. BY LOCAL REG. <u>6/5/1961</u>	26. REGISTRAR'S SIGNATURE <u>J. C. Canada</u>
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DATE AMENDED

INSTEAD OF

BY AFFIDAVIT OF

DOCUMENT

MEDICAL CERTIFICATION

**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. R. Allison

Licensed Embalmer No. 4404

P. O. Address Greenfield

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.