

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

285-61-024367  
STATE FILE NUMBER

AMENDED FILED JUL 17 1961  
Registration District No. 53 Primary Registration District No. 3010 Registrar's No. 285

1. PLACE OF DEATH a. COUNTY <b>Cape Girardeau</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>Bollinger</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Cape Girardeau</b>		Length of stay in lb <b>6 days</b>	c. CITY OR TOWN <b>Lutesville</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>S. E. Missouri Hospital</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <b>Anna Elizabeth Propst</b>			4. DATE OF DEATH Month Day Year <b>June 28 1961</b>	
------------------------------------------------------------------------------------------	--	--	-----------------------------------------------------------	--

5. SEX <b>Female</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>2-22-1881</b>	9. AGE (last birthday) <b>80</b>	IF UNDER 1 YEAR Months <b>4</b> Days <b>0</b>	IF UNDER 24 HR Hours <b>0</b> Min. <b>0</b>
-------------------------	----------------------------------	-------------------------------------------------------------------------------------------------------------------------------------------------------------	--------------------------------------	-------------------------------------	--------------------------------------------------	------------------------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Lutesville, Mo.</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
-----------------------------------------------------------------------------------------------------------------	-----------------------------------	----------------------------------------------------------------------	----------------------------------------------

13a. FATHER'S NAME <b>Calvin Craig</b>	13b. MOTHER'S MAIDEN NAME <b>Caroline Eaker</b>	14. NAME OF HUSBAND OR WIFE <b>George Propst</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>None</b>	17. INFORMANT <b>George Propst</b>	Address <b>Lutesville, 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>Pneumonitis - right</b>		INTERVAL BETWEEN ONSET AND DEATH
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>Arteriosclerotic Heart Disease with Acute Congestive Failure</b>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> N- <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 checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION <b>Cape Girardeau, Mo.</b>	COUNTY <b>Bollinger</b>	STATE <b>Mo.</b>
-------------------------------------------------------------------------------------------------------------------	------------------------------------------------------------------------------------------	------------------------------------------------------------	----------------------------	---------------------

21. I attended the deceased from **6-22-61** to **6-28-61** and last saw her **him** alive on **6-28-61**  
Death occurred at **12:12 p.m.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <b>J. H. Kerner, M.D.</b>	22b. ADDRESS <b>230 N. Sprigg Cape Girardeau, Mo.</b>	22c. DATE SIGNED <b>7-10-61</b>
---------------------------------------------------------------	--------------------------------------------------------------	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>July 1, 1961</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Cook Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Scopus, Mo.</b>
------------------------------------------------------------	----------------------------------	------------------------------------------------------------	---------------------------------------------------------------------

24. FUNERAL DIRECTOR <b>Baker Funeral Home</b>	ADDRESS <b>Lutesville, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>7-11-1961</b>	26. REGISTRAR'S SIGNATURE <b>James Karter</b>
---------------------------------------------------	-----------------------------------	--------------------------------------------------	--------------------------------------------------

DATE AMENDED  
 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
 INSTEAD OF  
 DOCUMENT  
 MEDICAL CERTIFICATION  
 SHOULD READ  
 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 J. E. Graham

Licensed Embalmer No. 4010

P. O. Address Lutesville, Md.

\*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.