

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-038221

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

AMENDED

Registration District No. 316 Primary Registration District No. 3057 Registrar's No. 436

FILED NOV 15 1961

1. PLACE OF DEATH a. COUNTY <b>ST FRANCOIS</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. <b>MISSOURI</b> b. COUNTY <b>T FRANCOIS</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>BONNE TERRE MO.</b>		Length of stay in 1b	c. CITY OR TOWN <b>FARMINGTON</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>BONNE TERRE HOSP</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>513 W COLUMBIA ST</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>KOSSUTH CAYCE WEBER</b>			4. DATE OF DEATH Month Day Year <b>NOV. 10 1961</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>11/9/79</b>	9. AGE (last birthday) <b>82</b>	IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>ATTORNEY AT LAW</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>FARMINGTON MO.</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>KOSSUTH WILLIAM WEBER</b>		13b. MOTHER'S MAIDEN NAME <b>ANNA CAYCE</b>		14. NAME OF HUSBAND OR WIFE <b>NAN WEBER</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.	17. INFORMANT Address <b>MRS NAN WEBER FARMINGTON 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) <u>Arteriosclerotic heart Disease</u> DUE TO (b) <u>Semility</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH <u>one wk.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Rt. lower lobe pneumonia</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	
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 s.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 <u>Nov 6, 1961</u> to <u>Nov 10, 1961</u> and last saw him alive on <u>Nov 9, 1961</u> Death occurred at <u>2 A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>R.A. Heckstap M.D.</u>			22b. ADDRESS <u>Farmington, MO.</u>		22c. DATE SIGNED <u>11/13/61</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>11/11/61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>MASONIC</b>	23d. LOCATION (City, town, or county) (State) <b>FARMINGTON MO.</b>		
24. FUNERAL DIRECTOR ADDRESS <b>C.H.COZEAN FARMINGTON MO.</b>		25. DATE RECD. BY LOCAL REG. <b>Nov. 13, 1961</b>	26. REGISTRAR'S SIGNATURE <u>Ether Rudloff</u>		

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

DEC 1 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 me  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed \_\_\_\_\_

*W. Cozart*

Licensed Embalmer No. 0408

P. O. Address Jarvis

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.