

# SOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=61-040102

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

Registered District No. 38 Primary Registration District No. 3006 Registrar's No. 714

AMENDED

FILED DEC 4 1961

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Boone</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Columbia</u> Length of stay in 1b <u>26 days</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>University of Missouri Medical Center</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN <u>High Hill</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>R. R. 1</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
---	--	---	--

<b>3. NAME OF DECEASED</b> (Type or print) First <u>Anton</u> Middle <u>Fredrick</u> Last <u>Engel</u>			<b>4. DATE OF DEATH</b> Month <u>November</u> Day <u>28</u> Year <u>1961</u>			
<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. Married</b> <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>Oct. 30, 1895</u>	<b>9. AGE</b> (last birthday) <u>86</u>	<b>IF UNDER 1 YEAR</b> - Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u> <b>IF UNDER 24 HR</b>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Farming</u>		<b>11. BIRTHPLACE</b> (City and state or country) <u>Jonesburg, Missouri</u>		<b>12. CITIZEN OF WHAT COUNTRY</b> <u>U. S. A.</u>

<b>13a. FATHER'S NAME</b> <u>John Engel</u>		<b>13b. MOTHER'S MAIDEN NAME</b> <u>Caroline</u>		<b>14. NAME OF HUSBAND OR WIFE</b> <u>Edna Engel</u>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> -----		<b>17. INFORMANT</b> <u>University of Missouri Medical Records</u> Address -----	

<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBROVASCULAR ACCIDENT (PROB. BASILAR ARTERY THROMBOSIS)</u> DUE TO (b) <u>GEN. SEVERE ARTERIOSCLEROSIS &amp; ASHD</u> <u>25 days</u> (c) <u>CHRONIC BILATERAL PYELONEPHRITIS</u> <u>1-2 YRS (+)</u>			INTERVAL BETWEEN ONSET AND DEATH <u>25 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>PREVIOUS CEREBROVASCULAR ACCIDENT</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

<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)	
---	--	---	--

<b>20c. TIME OF INJURY</b> Hour <u>  </u> a.m. / p.m. Month, Day, Year <u>  </u>	<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)	<b>20f. CITY, TOWN, OR LOCATION</b> COUNTY STATE
--	---	---	--

21. I attended the deceased from 11-3-61 to 11-28-61 and last saw him alive on 11-27-61  
 Death occurred at 1249 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.

<b>22a. SIGNATURE</b> (Degree or title) <u>J. E. Broadbuz, M.D.</u>	<b>22b. ADDRESS</b> <u>UNIVERSITY HOSPITAL COLUMBIA, MO.</u>	<b>22c. DATE SIGNED</b> <u>11-28-61</u>
--	---	--

<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>	<b>23b. DATE</b> <u>11-30-1961</u>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Jonesburg</u>	<b>23d. LOCATION</b> (City, town, or county) (State) <u>Jonesburg, Missouri</u>
---	---------------------------------------	---	--

<b>24. FUNERAL DIRECTOR</b> ADDRESS <u>Lyman Sprinkle, Columbia, Mo.</u>	<b>25. DATE RECD. BY LOCAL REG.</b> <u>Nov 28 1961</u>	<b>26. REGISTRAR'S SIGNATURE</b> <u>Mrs. R.E. Palmer</u>
---	---	---

**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 *Erman Sprinkle*

Licensed Embalmer No. 4013

P. O. Address Columbus, Mo

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.