

MOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-041948

STATE FILE NUMBER

Registration District No. 274 Primary Registration District No. 3052 Registrar's No. 357

FILED DEC 5 1961

1. PLACE OF DEATH a. COUNTY <u>Pettis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Pettis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Sedalia</u>		Length of stay in 1b <u>6 yrs</u>	c. CITY OR TOWN <u>Sedalia</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>Bothwell Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>R.F.D # 3</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Nettie</u> Middle <u>TABAT</u> Last <u>TABAT</u>			4. DATE OF DEATH Month <u>Nov</u> Day <u>27</u> Year <u>1961</u>			
--	--	--	---	--	--	--

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>5-24-1874</u>	9. AGE (last birthday) <u>87</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
-------------------------	----------------------------------	---	--------------------------------------	-------------------------------------	--	--

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

13a. FATHER'S NAME <u>Bruno Penning</u>	13b. MOTHER'S MAIDEN NAME <u>Dena Helen Even</u>	14. NAME OF HUSBAND OR WIFE <u>Julius Tabat</u>
--	---	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT <u>Mrs. Walter Burch</u> Address <u>R # 3 Sedalia</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
IMMEDIATE CAUSE (a)	<u>Pulmonary Embolism</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	<u>Localized peritonitis.</u>	
DUE TO (b)	<u>Enterocolic fistula</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>Carcinoma Colon (pending autopsy report)</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 checked="" 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 _____
--	--	--

21. I attended the deceased from 11 Nov 61 to 27 Nov 61 and last saw her live on 26 Nov 61
Death occurred at 0945 on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Karl D. Beigel M.D.</u> (Degree or title)	22b. ADDRESS <u>1216 West 18th St. Sedalia, Mo</u>	22c. DATE SIGNED <u>27 Nov 61</u>
--	---	--------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>11-27-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Hampton cem -</u>	23d. LOCATION (City, town, or county) (State) <u>Hampton Iowa</u>
---	------------------------------	--	--

24. FUNERAL DIRECTOR <u>Mc Laughlin Bros Sedalia</u>	ADDRESS	25. DATE RECD. BY LOCAL REG. <u>11-27-1961</u>	REGISTRAR'S SIGNATURE <u>Frances Shelby</u>
---	---------	---	--

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 K. P. McLeary

Licensed Embalmer No. 3158

P. O. Address Sedalia 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.