

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-014473

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 55 Primary Registration District No. _____ Registrar's No. _____

FILED MAY 8 1962	
1. PLACE OF DEATH a. COUNTY Carroll	
2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Carroll	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Tina Length of stay in 1b 23 years	
c. CITY OR TOWN Tiba Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Home John Deitch Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
d. STREET ADDRESS RFD (If outside, give location) Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CLIFFORD Middle Glyde Last DEITCH	
4. DATE OF DEATH May 1st, 1962 Month May Day 1st Year 1962	
5. SEX M	6. COLOR OR RACE White
7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 6/12/1895
9. AGE (last birthday) 66 IF UNDER 1 YEAR: Months 10 Days 19 IF UNDER 24 HR: Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer	
10b. KIND OF BUSINESS OR INDUSTRY Livestock farmer	
11. BIRTHPLACE (City and state or country) Lincoln, Nebraska	
12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME Fred Deitch	
13b. MOTHER'S MAIDEN NAME Minnie	
14. NAME OF HUSBAND OR WIFE Lila Alene (Flinn) Deitch	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	
16. SOCIAL SECURITY NO. no	
17. INFORMANT John Deitch, Tina, Missouri. Address _____	
18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Arteriosclerotic Chr.	
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.)	
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 6-6-61 to 4-23-62 and last saw him alive on 4-23-62 . Death occurred at 1:00 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE W. M. Powell, M.D. (Degree or title)	
22b. ADDRESS Chelliothe Mo	
22c. DATE SIGNED 5-1-62	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 5/3/1962
23c. NAME OF CEMETERY OR CREMATORY Wallace Cemetery	
23d. LOCATION (City, town, or county) (State) Jewell, Kansas.	
24. FUNERAL DIRECTOR Clifford W. Austin F-H Tina, Mo. ADDRESS _____	
25. DATE RECD. BY LOCAL REG. 5-8-62	
26. REGISTRAR'S SIGNATURE Mrs. Herbert Calvert Per [Signature] Deputy	

VS 300 Rev. 4/59
10170
20170
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4 0
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7 1
8 2
9 434.1
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12 90.0
13 1-0

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

Name of Deceased _____
 Address of Deceased _____
 Date of Death _____
 Name of Embalmer _____
 Address of Embalmer _____
 Date of Embalming _____
 Name of Undertaker _____
 Address of Undertaker _____
 Name of Funeral Home _____
 Address of Funeral Home _____

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 Clyfford W. Austin
 Licensed Embalmer No. #3233

P. O. Address Tina, Missouri.

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.