

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-035621

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB
 AMENDED
 VS 300 Rev. 4/59
 0740
 20790
 3
 4 0
 5 1
 6
 7 0
 8 2
 9/62.1
 10
 11
 12 90-0
 13 1-0
 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 BY AFFIDAVIT OF
 ITEM NO. SHOULD READ

Registration District No. 273 Primary Registration District No. _____ Registrar's No. 140

FILED OCT 10 1962

1. PLACE OF DEATH a. COUNTY <u>Perry</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Perry</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Altenburg</u>		Length of stay in 1b <u>Life</u>	c. CITY OR TOWN <u>Altenburg</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION			Inside Limits Yes <input checked="" type="checkbox"/> No <input 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 <u>Walter</u> Middle <u>E.</u> Last <u>Fritsche</u>			4. DATE OF DEATH Month <u>9</u> Day <u>29</u> Year <u>1962</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Never Married <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>5-2-1913</u>	9. AGE (last birthday) <u>49</u>	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) <u>Poultry House Owner</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Altenburg Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Reinhold Fritsche</u>		13b. MOTHER'S MAIDEN NAME <u>Ida Thurm</u>		14. NAME OF HUSBAND OR WIFE <u>Tabea Kuehnert</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>			17. INFORMANT Address <u>Tabea Fritsche Altenburg Mo.</u>			
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>Bronchiogenic carcinoma -</u>					INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____					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	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) _____						
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 <u>11-6-61</u> to <u>9-29-62</u> and last saw him alive on <u>9-17-62</u> Death occurred at <u>2:30 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>G. E. Fairhead, MD</u>			22b. ADDRESS <u>Perryville, Mo.</u>		22c. DATE SIGNED <u>9-29-62</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>10-1-1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Trinity Lutheran Cem.</u>		23d. LOCATION (City, town, or county) <u>Altenburg Mo.</u>	(State)	
24. FUNERAL DIRECTOR ADDRESS <u>Young & Sons Perryville Mo</u>			25. DATE RECD. BY LOCAL REG. <u>10-1-62</u>	26. REGISTRAR'S SIGNATURE <u>Joe J Zellner</u>		

APR 23 1963

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 Wallace Young

Licensed Embalmer No. 4027

P. O. Address Perryville 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.