

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-000545

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 47 Primary Registration District No. 3008 Registrar's No. 40

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED FEB 11 1963			
<p>1. PLACE OF DEATH</p> <p>a. COUNTY <u>Callaway</u></p> <p>b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Fulton</u> Length of stay in 1b <u>50 days</u></p> <p>c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Fulton State Hosp.</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)</p> <p>a. STATE <u>Mo.</u> b. COUNTY <u>Cole</u></p> <p>c. CITY OR TOWN <u>Lobman</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/></p>		
<p>3. NAME OF DECEASED First <u>ELIZABETH</u> Middle <u>B.</u> Last <u>GEMEINHARDT</u></p>			
<p>4. DATE OF DEATH Month <u>Febr.</u> Day <u>9</u> Year <u>1963</u></p>			
<p>5. SEX <u>Female</u></p>	<p>6. COLOR OR RACE <u>white</u></p>	<p>7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/></p>	<p>8. DATE OF BIRTH <u>Jan-12-1877</u></p>
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u></p>		<p>10b. KIND OF BUSINESS OR INDUSTRY <u>home</u></p>	
<p>11. BIRTHPLACE (City and state or country) <u>Missouri</u></p>		<p>12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u></p>	
<p>13a. FATHER'S NAME <u>Nicholas Linhardt</u></p>		<p>13b. MOTHER'S MAIDEN NAME <u>Eva Haggis</u></p>	
<p>14. NAME OF HUSBAND OR WIFE <u>unknown</u></p>		<p>16. SOCIAL SECURITY NO. [Redacted]</p>	
<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u></p>		<p>17. INFORMANT <u>State Hospital Records</u></p>	
<p>18. CAUSE OF DEATH (Enter only one cause per line. PART I. DEATH WAS CAUSED BY:</p> <p style="text-align: center;">IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u></p> <p style="text-align: center;">DUE TO (b) <u>Hypertensive Heart Disease</u></p> <p style="text-align: center;">DUE TO (c) <u>Cerebral arteriosclerosis</u></p> <p>Conditions, if any, which gave rise to above cause (a), starting the underlying cause, last.</p>			<p>INTERVAL BETWEEN ONSET AND DEATH</p>
<p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Chronic Brain Syndrome</u></p>			<p>PART III. If deceased was female was there a pregnancy in last 90 days.</p> <p><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown</p>
<p>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>	<p>20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/></p>	<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)</p>	
<p>20c. TIME OF INJURY Hour <u>2:15</u> Month, Day, Year <u>Feb 9-1963</u></p>			
<p>20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/></p>		<p>20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>	
<p>20f. CITY, TOWN, OR LOCATION <u>State Hospital</u></p>		<p>COUNTY _____ STATE _____</p>	
<p>21. I attended the deceased from <u>Jan 30-1963</u> to <u>Feb 9-1963</u> and last saw her alive on <u>Feb 9-1963</u></p> <p>Death occurred at <u>2:15</u> p.m. on the date stated above, and to the best of my knowledge, from the causes stated:</p>			
<p>22a. SIGNATURE (Degree or title) <u>Edward R. Kelley M.D.</u></p>		<p>22b. ADDRESS <u>State Hospital</u></p>	
<p>22c. DATE SIGNED <u>Feb 9-1963</u></p>		<p>(State)</p>	
<p>23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u></p>	<p>23b. DATE <u>2/16/63</u></p>	<p>23c. NAME OF CEMETERY OR CREMATORY <u>St Paul Cemetery</u></p>	<p>23d. LOCATION (City, town, or county) <u>Johann</u> (State) <u>Mo.</u></p>
<p>24. FUNERAL DIRECTOR <u>Lawson Stevenson</u> ADDRESS <u>Russellville</u></p>		<p>25. DATE RECD. BY LOCAL REG. <u>Feb 9-1963</u></p>	<p>26. REGISTRAR'S SIGNATURE <u>Maretha Lawrence</u></p>

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

VS 300
Rev. 4/59

1 0147

2 20260-

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9 9443X

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11 1293-0

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USE BLACK INK OR TYPEWRITER RIBBON

SEP 17 1963

0380
0147

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 J. H. Seaman

Licensed Embalmer No. 4073

P. O. Address Flower 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.