

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-007447
STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 172 Primary Registration District No. 5640 Registrar's No. _____

FILED FEB 25 1963

VS 300
Rev. 4/59

10540

20540

3

4 0

5 1

6

7 0

8 2

94201

10

11

12 96-0

13

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK
OR
TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY <u>Lafayette</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Lafayette</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Higginsville</u>		Length of stay in 1b <u>Rife</u>	c. CITY OR TOWN <u>Higginsville</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>6 mi. N.W. on Hi-way 13</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>6 mi. N.W. on Hi-way 13</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Robert Herman Tempel</u>			4. DATE OF DEATH Month Day Year <u>Febr. 19 1963</u>
5. SEX <u>m</u>	6. COLOR OR RACE <u>w</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>9/24/1909</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer + Stockman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Same</u>	11. BIRTHPLACE (City and state or country). <u>Higginsville Mo.</u>
13a. FATHER'S NAME <u>Will Tempel</u>		13b. MOTHER'S MAIDEN NAME <u>Katherine Rezman</u>	14. NAME OF HUSBAND OR WIFE <u>Mrs. Robert Tempel</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>		16. SOCIAL SECURITY NO. <u>[redacted]</u>	17. INFORMANT Address <u>Mr. Robert Tempel, Higginsville, Mo.</u>
18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY)			INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Coronary infarct.</u>			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>died after about 48 hrs. of [redacted]</u>			
DUE TO (c) <u>after a doctor's [redacted]</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a). <u>Overweight.</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 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>after death</u> to <u>never</u> and last saw him alive on <u>never</u> Death occurred at <u>2:15 PM</u> <u>4A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>[Signature]</u>		22b. ADDRESS <u>[Address]</u>	22c. DATE SIGNED <u>2-19-63</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>2/21/63</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park</u>	23d. LOCATION (City, town, or county) (State) <u>Lexington, Missouri</u>
24. FUNERAL DIRECTOR <u>Stiegers Rieckhof, Higginsville, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>2-25-63</u>	26. REGISTRAR'S SIGNATURE <u>[Signature]</u>

MAR 6 1963

0 p 2
0 p 2
0
0
0
0

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 *Frank A. Reckel*

Licensed Embalmer No. 04284

P. O. Address Higginsville 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.