

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=63-019610

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

DO NOT WRITE ON THIS SUB.

AMENDED

Registration District No. 109 Primary Registration District No. 5424 Registrar's No. 16

STATE FILE NUMBER

FILED MAY 20 1963

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY DUNKLIN		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY DUNKLIN	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN CAMPBELL, UNION TWP.		Length of stay in 1b 33 yrs.	c. CITY OR TOWN CAMPBELL Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION ROUTE # 1		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) ROUTE # 1. Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First HENRY Middle TIMMERMEIER Last TIMMERMEIER		4. DATE OF DEATH Month MAY Day 12 Year 1963	
5. SEX MALE	6. COLOR OR RACE WHITE	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 8-30-1874
10a. USUAL OCCUPATION (Give kind of work done during the year preceding death, even if retired) FARMING		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (last birthday) 80 yrs. IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HR: Hours _____ Min. _____
11a. BIRTHPLACE (City and state or country) ST. CHARLES, CO. MO.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME WALTER TIMMERMEIER		13b. MOTHER'S MAIDEN NAME UNKNOWN	
14. NAME OF HUSBAND OR WIFE NONE		17. INFORMANT Wm. STRATMAN, CAMPBELL, MO. (NEPHEW) Address _____	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage, hypertension, Cardiac failure. DUE TO (b) failure. Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			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 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 CAMPBELL, MO. COUNTY _____ STATE _____	
21. I attended the deceased from 1956 to 1963 and last saw him alive on May 7, 1963 Death occurred at 10:30 A m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>Dr. B. L. Franklin</i>		22b. ADDRESS Campbell, Mo.	
22c. DATE SIGNED 5/14/63		22d. (State)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE May 15, 1963	23c. NAME OF CEMETERY OR CREMATORY ST. TERESA CEMETERY	23d. LOCATION (City, town, or county) GLENNONVILLE, MO.
24. FUNERAL DIRECTOR DAY & KNIGHT F.H. ... MALDEN, MO.		25. DATE RECD. BY LOCAL REG. 5/18/1963	26. REGISTRAR'S SIGNATURE <i>Mrs. Beulah Campbell</i>

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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. D. Khourian

Licensed Embalmer No. 4086

P. O. Address Malden

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.