

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-027865

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 118 Primary Registration District No. 5441 Registrar's No. 22

STATE FILE NUMBER

**FILED JUL 29 1963**

1. PLACE OF DEATH a. COUNTY <b>GASCONADE</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>GASCONADE</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>THIRD CREEK TWP</b> Length of stay in 1b <b>63 yrs</b>		c. CITY OR TOWN <b>OWENSVILLE</b> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>RURAL ROUTE 2</b> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>FARM HOME</b> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		3. NAME OF DECEASED First Middle Last <b>WILHELMINA GAWER</b>			
4. DATE OF DEATH Month Day Year <b>JULY 20 1963</b>		5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>	
7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>12-14-1878</b>		9. AGE (last birthday) <b>84</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWORK</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>		11. BIRTHPLACE (City and state or country) <b>CHAMMOIS MO</b>	
12. CITIZEN OF WHAT COUNTRY <b>USA</b>		13a. FATHER'S NAME <b>JOHN STEPHEN</b>		13b. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>	
14. NAME OF HUSBAND OR WIFE <b>ALBERT GAWER</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <input type="checkbox"/>	
17. INFORMANT <b>ALBERT GAWER - OWENSVILLE MO</b>		18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Insufficiency</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last: DUE TO (b) <b>Atherosclerosis</b> DUE TO (c) <b>Hypertension</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b> <b>1 year</b> <b>1 year</b>	
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 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 <b>5-21-62</b> to <b>7-20-63</b> and last saw her alive on <b>7-16-63</b> Death occurred at <b>6 P.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <b>Renee Bannet, MD.</b> (Degree or title)		22b. ADDRESS <b>Owensville, Mo.</b>		22c. DATE SIGNED <b>7-22-63</b> (State)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>7-23-63</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ST JOHN E &amp; R CEM.</b>	
23d. LOCATION (City, town, or county) <b>WOOLLAM MO.</b>		24. FUNERAL DIRECTOR <b>GOTTENSTROETER FUNERAL HOME</b> <b>OWENSVILLE MO.</b>		25. DATE RECD. BY LOCAL REG. <b>July 23, 1963</b>	
26. REGISTRAR'S SIGNATURE <b>Mrs. Marjorie Jappmeyer</b>					

DO NOT WRITE ON THIS STUB  
 AMENDED  
 DATE AMENDED  
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 2 0370  
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 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
 INSTEAD OF  
 DOCUMENT  
 MEDICAL CERTIFICATION  
 BY AFFIDAVIT OF  
 ITEM NO. SHOULD READ  
 USE BLACK INK OR TYPEWRITER RIBBON

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 Jermy A. Thompson

Licensed Embalmer No. 5165

P. O. Address Owensville 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.