

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-034931

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 1 Primary Registration District No. 3000 Registrar's No. 298

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED SEP 18 1963

1. PLACE OF DEATH a. COUNTY <u>Adair</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Adair</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kirksville</u>		Length of stay in 1b <u>years</u>	c. CITY OR TOWN <u>Kirksville</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HASBROOK INSTITUTION <u>Nursing Home # 2</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>415 E. Elm St.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) VICTORIA DAUBRESSE			4. DATE OF DEATH Month <u>Sept.</u> Day <u>6</u> Year <u>1963</u>		
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. WIDOWED <input checked="" type="checkbox"/> MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>12/31/72</u>	9. AGE (last birthday) <u>90</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HR Hours <u> </u> Min. <u> </u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	11. BIRTHPLACE (City and state or country) <u>Lems, France</u>	12. CITIZEN OF WHAT COUNTRY <u> </u>
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13a. FATHER'S NAME <u>Henri Brocaille</u>	13b. MOTHER'S MAIDEN NAME <u>Philomane Ferney</u>	14. NAME OF HUSBAND OR WIFE <u>Ulysse Daubresse</u>
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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> </u>	17. INFORMANT Address <u>Lucille DesCamp, Kirksville, Mo.</u>
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18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Overwhelming toxemia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Nephrosclerosis</u>		<u>unknown</u>
DUE TO (c) <u> </u>		<u> </u>

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Generalized Arteriosclerosis</u>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
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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.) <u> </u>
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20c. TIME OF INJURY Hour <u> </u> a.m. <u> </u> p.m. <u> </u>	Month, Day, Year <u> </u> <u> </u> <u> </u>
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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.) <u> </u>	20f. CITY, TOWN, OR LOCATION <u> </u>	COUNTY <u> </u>	STATE <u> </u>
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21. I attended the deceased from 8-21-63 to 9-6-63 and last saw her live on 9-5-63
Death occurred at 1:55 A. m on the date stated above, and to the best of my knowledge, from the causes stated.

22. SIGNATURE (Degree or title) <u>George H. Schauer, D.O.</u>	22b. ADDRESS <u>Kirksville</u>	22c. DATE SIGNED <u>9-7-63</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>9-9-63</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Highland Park</u>	23d. LOCATION (City, town, or county) <u>Kirksville, Adair, Mo.</u>
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24. FUNERAL DIRECTOR <u>Foster Memorial Home, Kirksville, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>Sept 9, 1963</u>	26. REGISTRAR'S SIGNATURE <u>Nora W. Ratliff</u>
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(Licensed Embalmer's Statement on Reverse Side)

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DATE AMENDED
AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
INSTEAD OF
SHOULD READ

DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

No permit issued

GEORGE H. SCHURER, D.O.

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 *Nova E. Foster*
Nova E. Foster

Licensed Embalmer No. 4742

P. O. Address Kirksville, 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.