

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-043302

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 77 Primary Registration District No. 3016 Registrar's No. 456

FILED DEC 9 1963

VS 300
Rev. 4/59

1 0269

2 0260

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7 0

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12 86-0

13 3-0

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>COLE</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Cole</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>JEFFERSON CITY</u>		Length of stay in job <u>1 Month</u>	c. CITY OR TOWN <u>Lohman</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>JONES BEST Home</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>Lohman</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>ANNA</u> Middle <u>KATHRINE</u> Last <u>SAUER</u>			4. DATE OF DEATH Month <u>December</u> Day <u>3</u> Year <u>1963</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>July 30 1877</u>	9. AGE (last birthday) <u>86</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HR Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>		11. BIRTHPLACE (City and state or country) <u>Cole County Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13a. FATHER'S NAME <u>George HITZ</u>		13b. MOTHER'S MAIDEN NAME <u>BARBARA Weber</u>		14. NAME OF HUSBAND OR WIFE <u>AUGUST SAUER</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of <u>NO</u>)			16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT Address <u>CARL SAUER Russellville, Mo.</u>	

18. CAUSE OF DEATH (Enter only one cause per death) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Embolism</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Minutes</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Thrombophlebitis left leg</u>		<u>4 days</u>
DUE TO (c) <u>Assoc with Carcinomatous due to Ca of Colon</u>		<u>5 months</u>
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 <u> </u> Month, Day, Year <u> </u>		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>11-5-63</u> to <u>12-3-63</u> and last saw her <u>her</u> alive on <u>11-26-63</u> Death occurred at <u>12:45P</u> m. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>John J. Matthews, MD</u> (Degree or title)		22b. ADDRESS <u>302 Bolivar, Jefferson City Mo</u>	22c. DATE SIGNED <u>12-4-63</u> (State)
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>Dec. 5, 1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>ST. Pauls Cemetery</u>	23d. LOCATION (City, town, or county) <u>Lohman, Mo.</u>
24. FUNERAL DIRECTOR ADDRESS <u>SCRIVNER-STEVENSON - Russellville, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>4 December 1963</u>	26. REGISTRAR'S SIGNATURE <u>Norma E Richter</u>

(Licensed Embalmer's Statement on Reverse Side)

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 James K. Scrum

Licensed Embalmer No. 4880

P. O. Address Therock, 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.