

IRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS JUN 17 1960

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Registration District No. <u>77</u>		Primary Registration District No. <u>3016</u>		Registrar's No. <u>206</u>		STATE FILE NUMBER <u>206</u> <u>60-022538</u>	
1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
a. COUNTY <u>COLE</u>		a. STATE <u>MISSOURI</u>		b. COUNTY <u>MONITEAU</u>		b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>JEFFERSON CITY</u>		Length of stay in lb <u>13 Days</u>		c. CITY OR TOWN <u>CALIFORNIA</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>MEMORIAL COMMUNITY</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>IN CITY</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED				4. DATE OF DEATH			
First <u>AUGUST</u>		Middle <u>—</u>		Last <u>ALTHOFF</u>		Month <u>JUNE</u> Day <u>3</u> Year <u>1960</u>	
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>10-28-1885</u>	
9. AGE (last birthday) <u>74</u>		IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>		IF UNDER 24 HR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>GEN. FARMING</u>		11. BIRTHPLACE (City and state or country) <u>Mc GICK, MISSOURI</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>FRANK ALTHOFF</u>		13b. MOTHER'S MAIDEN NAME <u>SOPHIA KIRCHOFF</u>		14. NAME OF HUSBAND OR WIFE <u>NEVER MARRIED</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>NOT KNOWN</u>		17. INFORMANT <u>BENE ALTHOFF - CALIFORNIA, MO.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:						INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>	
IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u>							
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							
DUE TO (b) <u>—</u>							
DUE TO (c) <u>—</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Thrombosis left femoral artery</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.) <u>—</u>			
20c. TIME OF INJURY Hour <u>—</u> a.m. <u>—</u> p.m. <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.) <u>—</u>		20f. CITY, TOWN, OR LOCATION <u>—</u>		COUNTY <u>—</u> STATE <u>—</u>	
21. I attended the deceased from <u>5-15-60</u> , to <u>6-3-60</u> and last saw him alive on <u>6-2-60</u> Death occurred at <u>2:00</u> a.m. on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>E. L. Lloyd, M.D.</u>				22b. ADDRESS <u>Jeff. City, Mo.</u>		22c. DATE SIGNED <u>6-3-60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>6-4-60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Salem Evangelical</u>		23d. LOCATION (City, town, or county) (State) <u>CALIFORNIA MO.</u>	
24. FUNERAL DIRECTOR <u>Hugh Williams, CALIFORNIA, MO.</u>				25. DATE RECD. BY LOCAL REG. <u>3 June 1960</u>		26. REGISTRAR'S SIGNATURE <u>R.P. Harris, M.D. - Richter</u>	

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Russell C. Maag

Licensed Embalmer No. 4809

P. O. Address California

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.