

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 30 64 53 Primary Registration District No. ~~0000~~ ⁴⁰⁷⁴ Registrar's No. 3 77 STATE FILE NUMBER 0026147

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MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH -				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
a. COUNTY <u>Cape Girardeau</u>		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Oak Ridge</u>		Length of stay in lb <u>4 years</u>		a. STATE <u>Missouri</u> b. COUNTY <u>Cape Girardeau</u>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Home</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Oak Ridge</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ALFRED</u> Middle <u>H.</u> Last <u>RASCHE</u>				4. DATE OF DEATH Month <u>July</u> Day <u>15</u> Year <u>1964</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 11, 1892</u>	9. AGE (last birthday) <u>71</u>	IF UNDER 1 YEAR	IF UNDER 24 HR	
					Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer (retired)</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>		11. BIRTHPLACE (City and state or country) <u>Gordonville, Mo</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>
13a. FATHER'S NAME <u>William C. Rasche</u>			13b. MOTHER'S MAIDEN NAME <u>Fredericka Denecke</u>		14. NAME OF HUSBAND OR WIFE <u>Laura Thoma</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>N/A</u>	17. INFORMANT <u>Laura Thoma Rasche-Oak Ridge, Mo</u>	Address		
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
IMMEDIATE CAUSE (a)							<u>2 mo.</u>
DUE TO (b) <u>Coronary Thrombosis</u>							
DUE TO (c) <u>Generalized arteriosclerosis</u>							<u>3 yrs.</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 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> 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>Sept. 1961</u> to <u>7-15-64</u> and last saw him alive on <u>7-6-64</u> Death occurred at <u>3:00 p</u> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>E. F. McDonald, MD</u> (Degree or title)				22b. ADDRESS <u>Jackson, Mo.</u>		22c. DATE SIGNED <u>7-22-64</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Jul 17, 1964</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Zion Methodist Cem</u>		23d. LOCATION (City, town, or county) (State) <u>Gordonville, Missouri</u>			
24. FUNERAL DIRECTOR <u>Cracraft-Miller,</u> ADDRESS <u>Jackson, Mo</u>			25. DATE RECD. BY LOCAL REG. <u>7-27-64</u>	26. REGISTRAR'S SIGNATURE <u>Gene Kasten</u>			

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MAR 23 1965

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 *H. C. Craft*

Licensed Embalmer No. 4327

P. O. Address Jackson, 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.