

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

67 0044548

STATE FILE NUMBER

Registration District No. 206 Primary Registration District No. 3042 Registrar's No. 672

DO NOT WRITE
ON THIS STUB

AMENDED

FILED NOV 16 1967

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Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

USE BLACK INK
OR
TYPEWRITER RIBBON

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

| | | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1. PLACE OF DEATH a. COUNTY <u>Madison</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St Francois</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Fredericktown</u> | | Length of stay in 1b <u>6 days</u> | c. CITY OR TOWN <u>Farmington</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Madison Memorial Hospital</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) <u>R.R. 1</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First <u>Alvin</u> Middle <u>E.</u> Last <u>Korber</u> | | | 4. DATE OF DEATH Month <u>November</u> Day <u>10</u> Year <u>1967</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>9/7/1891</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u> | 9. AGE (last birthday) <u>76</u> |
| 11. BIRTHPLACE (City and state or country) <u>Farmington, Missouri</u> | | 12. CITIZEN OF WHAT COUNTRY <u>USA</u> | |
| 13a. FATHER'S NAME <u>William Korber</u> | | 13b. MOTHER'S MAIDEN NAME <u>Elizabeth Regina Beck</u> | 14. NAME OF HUSBAND OR WIFE <u>Adeline Bieser Korber</u> |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>498-07-2119</u> | 17. INFORMANT <u>Mrs Adeline Korber, Farmington, Mo. R.R. 1</u> Address |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Interruption of O₂ cycle</u> DUE TO (b) <u>Cerebral Vascular Accident</u> DUE TO (c) Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | | INTERVAL BETWEEN ONSET AND DEATH <u>immediate</u> <u>Week-</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 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 <u>10-23-67</u> to <u>11-10-67</u> and last saw him alive on <u>11-10-67</u> Death occurred at <u>11:30</u> p.m. on the date stated above, and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE <u>Donald C. Demilyer</u> (Degree or title) | | 22b. ADDRESS <u>Farmington Mo.</u> | 22c. DATE SIGNED <u>11-15-67</u> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE <u>11/14/67</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>K-P Cemetery</u> | 23d. LOCATION (City, town, or county) (State) <u>Farmington, Missouri</u> |
| 24. FUNERAL DIRECTOR <u>Miller Funeral Home Inc, Farmington, Mo.</u> ADDRESS | | 25. DATE RECD. BY LOCAL REG. <u>11-13-67</u> | 26. REGISTRAR'S SIGNATURE <u>A. E. Sellenreich Reg. Prof. Mo.</u> |

NOV 21 1967

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 Paul K. Deegal

Licensed Embalmer No. 4120

P. O. Address Farmington 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.