

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **9518**

FILED MAR 23 1953

BIRTH NO. _____		REG. DIST. NO. 128		PRIMARY REG. DIST. NO. 5464		Registrar's No. 284	
1. PLACE OF DEATH a. COUNTY GREENE				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY GREENE			
b. CITY (If outside corporate limits, write RURAL and give township) RURAL MURRAY			c. LENGTH OF STAY (in this place)			c. CITY (If outside corporate limits, write RURAL and give township) RURAL MURRAY 0390	
d. FULL NAME OF HOSPITAL OR INSTITUTION WILLARD ROUTE 2				d. STREET ADDRESS (If rural, give location) WILLARD ROUTE 2			
3. NAME OF DECEASED (Type or Print)		a. (First) SARAH		b. (Middle) VICTORIA LEE		c. (Last) DAVIE	
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED		4. DATE OF DEATH (Month) (Day) (Year) MARCH 17 1953	
8. DATE OF BIRTH AUG. 17, 1873		9. AGE (In years last birthday) 80		IF UNDER 1 YEAR Months		IF UNDER 1 HR. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOMEMAKING		11. BIRTHPLACE (State or foreign country) MISSOURI		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME GREEN LEE ROBBERSON			13b. MOTHER'S MAIDEN NAME YANDLES			14. NAME OF HUSBAND OR WIFE Mrs. LeRoy D. Breesse Willard R. 2	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. No		17. INFORMANT'S SIGNATURE OR NAME Mrs. LeRoy D. Breesse Willard R. 2		ADDRESS Willard R. 2	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.</i>		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cardio-Renal-Vascular Disease ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 42x				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 3-16 , 19 53 , to 3-16 , 19 53 , that I last saw the deceased alive on March 16, 1953 , and that death occurred at 6:20 P.M. , from the causes and on the date stated above.							
23a. SIGNATURE (Type or Print) M. O.				23b. ADDRESS Springfield Mo.		23c. DATE SIGNED 3-18-53	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 3-20-53		24c. NAME OF CEMETERY OR CREMATORY Lutheran Cemetery		24d. LOCATION (City, town, or county) (State) Marshfield Mo.	
DATE REC'D BY LOCAL REG. 3-18-53		REGISTRAR'S SIGNATURE Edith Williamson Registrar		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS J. W. Klingner & Co. Springfield, Mo.			

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

APR 16 1953

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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
Student Embalmer

Signed Ogle Stone Jr.

Licensed Embalmer No. 4176

P. O. Address Springfield

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 this body is not embalmed, fact should be so stated above.