

FILED MAY 1 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **13875**BIRTH NO. _____ REG. DIST. NO. **171** PRIMARY REG. DIST. NO. **5639** Registrar's No. **16**

1. PLACE OF DEATH a. COUNTY Lafayette		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Lafayette	
b. CITY OR TOWN Rural Washington Twp. 10 Twp.		c. CITY OR TOWN near Odessa	d. Is residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. LENGTH OF STAY (in this place)		e. STREET ADDRESS (If rural, give location)	
d. FULL NAME OF HOSPITAL OR INSTITUTION 6 Miles south of Odessa		6 miles south of Odessa	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH (Month) (Day) (Year)	
a. (First) Edith b. (Middle) Sandage c. (Last)		April 26, 1956	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow	8. DATE OF BIRTH February 12, 1877
9. AGE (In years last birthday) 79		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	11. BIRTHPLACE (City and State or Foreign Country) Harrison Co. Mo.
10a.		11b. KIND OF BUSINESS OR INDUSTRY	12. CITIZEN OF WHAT COUNTRY?
13a. FATHER'S NAME Robert Johnson		13b. MOTHER'S MAIDEN NAME Margaret Smith	14. NAME OF HUSBAND OR WIFE None
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME Mrs. Horace Chrisman, Odessa, Mo.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage		DUE TO (b)		12 hr.
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		DUE TO (c) Arteriosclerosis Sen		7 days
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Chronic Bronchitis				
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		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 **Apr 16, 1956**, to **Apr 26, 1956**, that I last saw the deceased alive on **Apr 25, 1956**, and that death occurred at **7 A.M.**, from the causes and on the date stated above.

23a. SIGNATURE E. J. Haughey, D.O.	23b. ADDRESS Odessa Mo	23c. DATE SIGNED 4/26/56
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Apr. 28, 1956	24c. NAME OF CEMETERY OR CREMATORY Concord Cemetery
		24d. LOCATION (City, town, or county) (State) Near Odessa, Mo.

DATE REC'D BY LOCAL REG. 4-26-56	REGISTRAR'S SIGNATURE Emma Davidson Davidson	FUNERAL DIRECTOR'S SIGNATURE John Sparks	ADDRESS Odessa, Mo.
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(Licensed Embalmer's Statement on Reverse Side)

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

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 *William T. Spair*

Licensed Embalmer No. *44*

P. O. Address *Odessa*

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.