

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

5729

State File No.

FILED MAR 4 1957

BIRTH NO. 8547-57 REG. DIST. NO. 274 PRIMARY REG. DIST. NO. 3052 Registrar's No. 145

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

1. PLACE OF DEATH a. COUNTY Pettis		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). —a.—STATE Missouri b. COUNTY Pettis	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Sedalia		c. LENGTH OF STAY (in this place) 2 days	c. CITY OR TOWN Sedalia 0800
d. FULL NAME OF HOSPITAL OR INSTITUTION Bothwell Hospital		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
• STREET ADDRESS (If rural, give location) Route 2			
3. NAME OF DECEASED (Type or Print) a. (First) TERRY b. (Middle) LYNN c. (Last) CRAMER			4. DATE OF DEATH (Month) (Day) (Year) Feb. 28, 1957
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED	8. DATE OF BIRTH Feb. 26, 1957
9. AGE (In years last birthday)		10. KIND OF BUSINESS OR INDUSTRY *****	11. BIRTHPLACE (City and State or Foreign Country) Sedalia, Missouri
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) *****		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Omer Cramer		13b. MOTHER'S MAIDEN NAME Patricia Lemmon	14. NAME OF HUSBAND OR WIFE *****
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) *****		16. SOCIAL SECURITY NO. *****	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Omer Cramer, Rt. 2, Sedalia, Mo.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Atherosclerosis, bilateral ANTECEDENT CAUSES Hyaline membrane 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.	
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) 5272
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		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 Feb 26, 1957 , to Feb 28, 1957 , that I last saw the deceased alive on Feb 28, 1957 , and that death occurred at 4:20 a.m. , from the causes and on the date stated above.			
23a. SIGNATURE P. V. Siegel MD (Degree or title)		23b. ADDRESS Smithton Mo	23c. DATE SIGNED 3/1/57
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 3/1/57	24c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery	24d. LOCATION (City, town, or county) (State) Sedalia, Missouri
DATE REC'D BY LOCAL REG. 3/1/57		REGISTRAR'S SIGNATURE Frances Shelby	25. FUNERAL DIRECTOR'S SIGNATURE . ADDRESS Diane Ewing Sedalia, Mo.

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Dr. Pete Seigel

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

P. E. Baker

Licensed Embalmer No. *2419*

P. O. Address *Secalia*

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.