

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

16421

STATE FILE NUMBER

FILED MAY 27 1957

Registration District No. 53 Primary Registration District No. 3009 Registrar's No. 280

Health,
& Welfare
Public
Service

S. 300
V. 1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY <u>Cape Girardeau</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Cape Girardeau</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Jackson mo</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Jackson mo</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>617 N. Maryland</u> Length of stay in 1b <u>3</u>		d. STREET ADDRESS (If outside, give location) <u>617 N. Maryland</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Ida</u> Middle <u>Sawyers</u> Last <u>Sawyers</u>		4. DATE OF DEATH <u>May 18-1957</u> Month <u>May</u> Day <u>18</u> Year <u>1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>w</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 20 1882</u> Month <u>May</u> Day <u>20</u> Year <u>1882</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Keeping House</u>	
11. BIRTHPLACE (City and state or country) <u>Kepping Home Ballinger Co. Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Berthold Schrocks</u>		14. MOTHER'S MAIDEN NAME <u>unknown</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>none</u>	
17. INFORMANT <u>Steve Sawyers</u>		Address <u>Millersville</u>	
18. CAUSE OF DEATH [Enter only one cause for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic myocardial infarction</u> DUE TO (b) <u>Coronary thrombosis</u> DUE TO (c) <u>Hypertensive arteriosclerotic cardiovascular disease</u>			INTERVAL BETWEEN ONSET AND DEATH <u>few hours</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART-I(n) <u>Auricular fibrillation + cardiac decompensation</u>			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.) <u>Post 5 mos.</u>	
20c. TIME OF INJURY Hour <u>2</u> Month <u>May</u> Day <u>18</u> Year <u>1957</u> a. m. <u>am</u> p. m.		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 <u>Jackson</u> COUNTY <u>Missouri</u> STATE <u>MO</u>	
21. I attended the deceased from <u>June 1954</u> to <u>18 May 1957</u> and last saw her alive on <u>7 May 1957</u> . Death occurred <u>about 11 am</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>J. H. Trolinger, M.D.</u>		22b. ADDRESS <u>J. H. TROLINGER, M. D. JACKSON, MISSOURI</u>	
22c. DATE SIGNED <u>5/21/57</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>5/21/57</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Russell Heights</u>		23d. LOCATION (City, town, or county) (State) <u>Jackson MO</u>	
24. FUNERAL DIRECTOR <u>Donette-Loid Jackson</u> ADDRESS <u>Jackson</u>		25. DATE RECD. BY LOCAL REG <u>5-22-1957</u>	
26. REGISTRAR'S SIGNATURE <u>C. C. Summers</u>			

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(Licensed Embalmer's Statement on Reverse Side)

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 *R. O. Laird*.....

Licensed Embalmer No. *4534*

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.