

diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.
 USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
 MEDICAL CERTIFICATION

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

28761
 STATE FILE NUMBER

FILED AUG 21 1957

Registration District No. 209 Primary Registration District No. 3043 Registrar's No. 320

1. PLACE OF DEATH a. COUNTY <u>Marion</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Audrain</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR <u>Hannibal</u> TOWN		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Vandalia</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>St. Elizabeth's Hosp</u>		Length of stay in lb	d. STREET ADDRESS <u>210 West Park</u> (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) <u>Sarah</u> ^{First} <u>Ellen</u> ^{Middle} <u>Evans</u> ^{Last}			4. DATE OF DEATH Month <u>Aug</u> Day <u>11</u> , 1957 Year		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sep 21, 1872</u>	9. AGE (In years last birthday) <u>84</u>	IF UNDER 1 YEAR Months _____ Days _____
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>Farm</u>	11. BIRTHPLACE (City and state or country) <u>Audrain County, Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>
13. FATHER'S NAME <u>William H. Beshears</u>			14. MOTHER'S MAIDEN NAME <u>Mary E. Treadway</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.	17. INFORMANT <u>Paul Evans, Monroe City, Mo.</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>inanition</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>general debility, progressive</u>	<u>3 months</u>
	DUE TO (c) <u>cerebral arteriosclerosis</u>	<u>2 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <u>2</u>

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.		
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>7-20-57</u> to <u>8-11-57</u> and last saw ^{her} <u>him</u> alive on <u>8-11-57</u> Death occurred at <u>11:50 PM</u> m on the date stated above; and to the best of my knowledge, from the causes stated.		
22a. SIGNATURE <u>F. E. Sultzman M.D.</u> (Degree or title)	22b. ADDRESS <u>115 N. 5th St. Hannibal, Mo.</u>	22c. DATE SIGNED <u>8-15-57</u>

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Aug 13, 1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Vandalia Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Vandalia, Missouri</u>
FUNERAL DIRECTOR <u>William B. Waters</u> ADDRESS <u>Vandalia, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>8-17-57</u>	26. REGISTRAR'S SIGNATURE <u>St. Em. Lucke</u>

RECEIVED AUG 20 1957
MARION CO. HEALTH DEPT.
DATE FILED AUG 20 1957

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was e
by me, or by, Student Embalmer No.....
working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *William P. Waters*.....

Licensed Embalmer No. *41*

P. O. Address *Vandalia*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING.
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.