

Health,  
& Welfare  
S. Public  
th Service

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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

FILED DEC 30 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

43364

STATE FILE NUMBER

Registration District No. 1 Primary Registration District No. 3000 Registrar's No. 437

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                   |                                                                                                                                                                        |                                                                                              |                                                                                                                                          |                                                                    |                                                                                      |                                                                                       |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------|--------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Adair</u>                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                   |                                                                                                                                                                        |                                                                                              | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Missouri</u> b. COUNTY <u>Adair</u> |                                                                    |                                                                                      |                                                                                       |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <u>Kirksville</u>                                                                                                                                                                                                                                                                                                                                                                                           |                                   |                                                                                                                                                                        | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>         | c. CITY OR TOWN <u>Kirksville</u>                                                                                                        |                                                                    | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | <u>2013</u>                                                                           |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Grim-Smith Hospital</u>                                                                                                                                                                                                                                                                                                                                                                           |                                   |                                                                                                                                                                        | Length of stay in lb <u>2 hr. 40min.</u>                                                     |                                                                                                                                          | d. STREET ADDRESS (If outside, give location) <u>1502 N. Elson</u> |                                                                                      | Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Fannie</u> Middle <u>Maude</u> Last <u>Rosenburger</u>                                                                                                                                                                                                                                                                                                                                                                           |                                   |                                                                                                                                                                        |                                                                                              | 4. DATE OF DEATH<br>Month <u>Dec.</u> Day <u>13</u> Year <u>1957</u>                                                                     |                                                                    |                                                                                      |                                                                                       |
| 5. SEX<br><u>Female</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 6. COLOR OR RACE<br><u>White</u>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                              | 8. DATE OF BIRTH<br><u>8-26-76</u>                                                                                                       |                                                                    | 9. AGE (In years last birthday)<br><u>81</u>                                         | IF UNDER 1 YEAR<br>Months <u>  </u> Days <u>  </u>                                    |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Housekeeping</u>                                                                                                                                                                                                                                                                                                                                                               | 10b. KIND OF BUSINESS OR INDUSTRY |                                                                                                                                                                        | 11. BIRTHPLACE (City and state or country)<br><u>Winnebago Co. Wisconsin</u>                 |                                                                                                                                          | 12. CITIZEN OF WHAT COUNTRY?<br><u>America</u>                     |                                                                                      |                                                                                       |
| 13. FATHER'S NAME<br><u>Austin Eggleston</u>                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                   |                                                                                                                                                                        | 14. MOTHER'S MAIDEN NAME<br><u>Emily Drake</u>                                               |                                                                                                                                          |                                                                    |                                                                                      |                                                                                       |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><u>No</u>                                                                                                                                                                                                                                                                                                                                                           |                                   | 16. SOCIAL SECURITY NO.                                                                                                                                                |                                                                                              | 17. INFORMANT<br><u>Grim-Smith Hospital, Kirksville, Mo.</u>                                                                             |                                                                    |                                                                                      |                                                                                       |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute myocardial failure.</u><br><br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.<br>DUE TO (b) <u>Chronic myocardial failure.</u><br>DUE TO (c) <u>  </u><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) |                                   |                                                                                                                                                                        |                                                                                              |                                                                                                                                          |                                                                    | INTERVAL BETWEEN ONSET AND DEATH<br><u>About 12 hr</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<br>Hour <u>  </u> Month <u>  </u> Day <u>  </u> Year <u>  </u><br>a. m. <u>  </u> p. m. <u>  </u>                                                                                                                                                                                                                                                                                                                                                            |                                   |                                                                                                                                                                        |                                                                                              |                                                                                                                                          |                                                                    |                                                                                      |                                                                                       |
| 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<br><u>  </u> COUNTY <u>  </u> STATE <u>  </u>                                                               |                                                                    |                                                                                      |                                                                                       |
| 21. I attended the deceased from <u>5 p.m. on 12-13-57 6:10 p.m. 12-13-57</u> and last saw <u>her</u> alive on <u>12-13-57</u><br>Death occurred at <u>6:10</u> pm on the date stated above; and to the best of my knowledge, from the causes stated.                                                                                                                                                                                                                            |                                   |                                                                                                                                                                        |                                                                                              |                                                                                                                                          |                                                                    |                                                                                      |                                                                                       |
| 22a. SIGNATURE<br><u>O. W. Hasselblad, M.D.</u> (Degree or title)                                                                                                                                                                                                                                                                                                                                                                                                                |                                   |                                                                                                                                                                        | 22b. ADDRESS<br><u>Kirksville, Missouri</u>                                                  |                                                                                                                                          | 22c. DATE SIGNED<br><u>12-14-57</u>                                |                                                                                      |                                                                                       |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                        | 23b. DATE                         | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                                     |                                                                                              | 23d. LOCATION (City, town, or county) (State)                                                                                            |                                                                    |                                                                                      |                                                                                       |
| <u>Burial</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | <u>12-16-1957</u>                 | <u>Prarie View</u>                                                                                                                                                     |                                                                                              | <u>Azen Mo</u>                                                                                                                           |                                                                    |                                                                                      |                                                                                       |
| 24. FUNERAL DIRECTOR<br><u>Al Papa, Son</u>                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                   | ADDRESS<br><u>Memphis Mo</u>                                                                                                                                           | 25. DATE RECD. BY LOCAL REG.<br><u>12-22-1957</u>                                            | 26. REGISTRAR'S SIGNATURE<br><u>Doris W. Rathff</u>                                                                                      |                                                                    |                                                                                      |                                                                                       |

(Licensed Embalmer's Statement on Reverse Side)

5 3 5

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. D. Payne*.....

Licensed Embalmer No. *219*

P. O. Address *Memphis*

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.