

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

2098

STATE FILE NUMBER

FILED FEB 11 1958

Registration District No. 236

Primary Registration District No. 5818

Registrar's No. 10

1. PLACE OF DEATH a. COUNTY <u>Morgan</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before death) a. STATE <u>Missouri</u> b. COUNTY <u>Morgan</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Marsden</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <u>Versailles</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>5 M. N. C. Vers. Lifetime</u>		Length of stay in lb	d. STREET ADDRESS (If outside, give location) <u>5 M. N. C. Vers.</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Sarah</u> Middle <u>A.</u> Last <u>Diener</u>			4. DATE OF DEATH Month <u>Feb.</u> Day <u>5</u> Year <u>1958</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 17, 1877</u>		9. AGE (In years last birthday) <u>80</u> IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
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>None</u>		11. BIRTHPLACE (City and state or country) <u>Elkton, Mo.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13a. FATHER'S NAME <u>Peter Raber</u>		13b. MOTHER'S MAIDEN NAME <u>Elizabeth Gilliom</u>	
14. NAME OF HUSBAND OR WIFE <u>Moses M. Diener</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>Moses M. Diener</u>		Address <u>Versailles, Mo.</u>			
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>Bronchopneumonia</u>					INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Multiple cerebral thrombi</u>					<u>3 years</u>
DUE TO (c) <u>Hypertension</u>					<u>10 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"/>
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 Month, Day, Year a.m. p.m.					
20d. INJURY OCCURRED WHILE AT <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>JAN 1955</u> to <u>Feb 5 1958</u> and last saw her <u>alive on Feb 5 1958</u> Death occurred at <u>7:30 P</u> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>Jack Gunn M.D.</u>		(Degree or title)		22b. ADDRESS <u>Versailles, Mo.</u>	
22c. DATE SIGNED <u>2.6.58</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>9 Feb. 58</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Zion Cemetery</u>	
23d. LOCATION (City, town, or county) (State) <u>Morgan Co., Mo.</u>					
24. FUNERAL DIRECTOR <u>W. F. Kidwell Versailles, Mo.</u>		ADDRESS		25. DATE RECD. BY LOCAL REG. <u>2-8-58</u>	
26. REGISTRAR'S SIGNATURE <u>J. L. Wash</u>					

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

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 *Raymond C. Lusher*
Licensed Embalmer No. *4626*
P. O. Address *Winnfield, 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.