

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-006-1909
STATE FILE NUMBER

FILED FEB 24 1958

Registration District No. 274 Primary Registration District No. 5924 Registrar's No. 124

300
1-5700
Dy
1

1. PLACE OF DEATH a. COUNTY <u>Pettis</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Benton</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Sedalia</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>FAIRFIELD 2089</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>Millers Cafe Hwy 50</u>		Length of stay in <u>2 weeks</u>	d. STREET ADDRESS (If outside, give location) <u>8 miles S. W.</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>SARAH ANNIE BRESKEARS</u>			4. DATE OF DEATH Month Day Year <u>Feb 16 1958</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Apr 10, 1890</u>	9. AGE (In years last birthday) <u>67</u>	10. UNDER 1 YEAR Months Days Hours Min. <u>10 6</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>Home</u>	11. BIRTHPLACE (City and state or country) <u>Benton Co. Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>
13a. FATHER'S NAME <u>Martin Hoppers</u>		13b. MOTHER'S MAIDEN NAME <u>Adeline Foster</u>		14. NAME OF HUSBAND OR WIFE <u>John Harrison Bushears</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give wt or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT Address <u>John Harrison Bushears Fairfield</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>Pulmonary embolism</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) <u>years</u>					INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Recent - little stroke Jan 58</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 WORK <input type="checkbox"/> 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>12 Jan 58</u> to <u>16 Feb 58</u> and last saw her <u>alive</u> on <u>8 Feb 58</u> Death occurred at <u>3:30 PM</u> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>Carl D. Siegel M.D.</u>			22b. ADDRESS <u>1216 West 18th St, Sedalia, Mo 64288</u>		22c. DATE SIGNED <u>Feb 16 1958</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>Feb 21, 1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Shiloh Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Bentonville Benton Co. Mo</u>
24. FUNERAL DIRECTOR <u>Kiser Funeral Home</u>		ADDRESS <u>Warsaw</u>		25. DATE RECD. BY LOCAL REG. <u>2-20-1958</u>	26. REGISTRAR'S SIGNATURE <u>Frances Shelby</u>

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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *John F. Reser*

Licensed Embalmer No. *4098*
P. O. Address *Warsaw*

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.