

Dr. Health,  
& Welfare  
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THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-028138

STATE FILE NUMBER

FILED SEP 9 1958 Registration District No. 16 Primary Registration District No. 4030 Registrar's No. 13

1. PLACE OF DEATH a. COUNTY <b>Barton</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Barton</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Golden City</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Golden City 0060</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>At Home</b>		Length of stay in 1b <b>22 yrs.</b>	d. STREET ADDRESS (If outside, give location) <b>----</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>BERTHA BEATRICE DEMSTER</b>			4. DATE OF DEATH Month Day Year <b>Aug. 30, 1958</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 27, 1885</b>		9. AGE (In years last birthday) <b>73</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	11. BIRTHPLACE (City and state or country) <b>Montgomery Co., Mo.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13a. FATHER'S NAME <b>Joseph Baugh</b>		13b. MOTHER'S MAIDEN NAME <b>Drucilla Dillian</b>		14. NAME OF HUSBAND OR WIFE <b>Thomas Demster</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT Address <b>Thomas Demster, Golden City, Mo.</b>	
18. CAUSE OF DEATH (Enter only one cause per line in (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b>					INTERVAL BETWEEN ONSET AND DEATH <b>12 days</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) <b>331X</b>					
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 <input type="checkbox"/> WORK 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 <b>Aug 18, 1958</b> to <b>Aug 30, 1958</b> and last saw her alive on <b>Aug 30, 1958</b> Death occurred at <b>9:43 p</b> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Doctor or title) <b>Raymond A. Carlson</b>			22b. ADDRESS <b>403 Main St. Golden City, Mo.</b>		22c. DATE SIGNED <b>9-3-58</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Sept. 4, 1958</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Moorehead Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Barton Co., Mo.</b>
24. FUNERAL DIRECTOR <b>Phillips Funeral Home, Golden City, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>Sept 3-1958</b>		26. REGISTRAR'S SIGNATURE <b>Hazel St. Pugh</b>	

(Licensed Embalmer's Statement on Reverse Side)

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

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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 *H. J. Bugh* .....

Licensed Embalmer No. *3278*

P. O. Address *Golden City*

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.