

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-043336
STATE FILE NUMBER

FILED DEC 29 1958 Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 1369

300
-57

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Buchanan	
b. CITY OR TOWN St. Joseph		c. CITY OR TOWN Hamilton	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION State Hospital #2		d. STREET ADDRESS (If outside, give location) none	
3. NAME OF DECEASED First MINNIE Middle none Last STURGIS		4. DATE OF DEATH December 22, 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 24, 1877
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (City and state or country) Trenton, Missouri
13a. FATHER'S NAME Ada Dye		13b. MOTHER'S MAIDEN NAME Methina ----	14. NAME OF HUSBAND OR WIFE W. J. Sturgis
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT State Hospital Records		Address St. Joseph, Mo.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia			INTERVAL BETWEEN ONSET AND DEATH 3 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____			
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"/> 2
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. Month, Day, Year		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 June 1958, to Dec. 22, 1958 and last saw her alive on Dec. 22, 1958. Death occurred at 1:50 P. m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Mohammad Gaber M.D.		22b. ADDRESS State Hospital #2., St. Joseph, Mo.	
22c. DATE SIGNED 12/22/58			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE Dec. 22, 1958	23c. NAME OF CEMETERY OR CREMATORY Bram Funeral Home	23d. LOCATION (City, town, or county) (State) Hamilton, Missouri.
24. FUNERAL DIRECTOR Meyerhoffer Fleeman, Inc. St. Joseph, Mo.		25. DATE RECD. BY LOCAL REG. Dec. 23, 1958	26. REGISTRAR'S SIGNATURE Mrs. Clark Woodell

MEDICAL CERTIFICATION
All diseases in Part I must be causally related.
Dr. Mohammad Tahir
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 *Robert E. Harrington*

Licensed Embalmer No. 3258

P. O. Address St. Joseph, 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.