Health, Welfare Public Service

300
1-57

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-000906
STATE FILE NUMBER

FILED JAN 20 1959 Registration District No. 120 Primary Registration District No. Registrar's No. 6

1. PLACE OF DEATH
a. COUNTY GENTRY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN STANBERRY — Inside Limits Yes ☑ No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION W. 6TH STREET — Length of stay in Hospital 35 yrs.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY GENTRY
c. CITY OR TOWN STANBERRY — Inside Limits Yes ☑ No ☐
d. STREET ADDRESS W. 6TH ST. (If outside, give location) — Reside on Farm Yes ☐ No ☑

3. NAME OF DECEASED (Type or print) First MRS. ADA Middle — Last SAGER

4. DATE OF DEATH Month JAN. Day 3. Year 1959

5. SEX FEMALE
6. COLOR OR RACE WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ 2 DIVORCED ☐
8. DATE OF BIRTH AUG. 15 1877
9. AGE (In years last birthday) 81 — 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) HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY HOME
11. BIRTHPLACE (City and state or country) GENTRY Co. MO.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME LITTON BOYD
13b. MOTHER'S MAIDEN NAME LOUISA HARDIN
14. NAME OF HUSBAND ~~OR WIFE~~ JACOB SAGER (DECEASED)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service) NO
16. SOCIAL SECURITY NO. NONE
17. INFORMANT MRS. PAUL DANIEL Address STANBERRY, MO.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Lukemia — INTERVAL BETWEEN ONSET AND DEATH years.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Unknown
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) arterio sclerotic heart disease 2044
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
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 1-1-59, to 1-3-59 and last saw her ~~him~~ alive on 1-3-59
Death occurred at 9:00 P.M. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Ward L. Carlin MD (Degree or title)
22b. ADDRESS Stanberry, MO.
22c. DATE SIGNED 1-10-59

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
23b. DATE JAN. 6-1959
23c. NAME OF CEMETERY ~~OR CREMATORY~~ MT. ZION
23d. LOCATION (City, town, or county) (State) 4 mi. S.E. of STANBERRY, MO.

24. FUNERAL DIRECTOR ADDRESS JOHNSON FUNERAL HOME - STANBERRY, MO.
25. DATE RECD. BY LOCAL REG. 1-12-59
26. REGISTRAR'S SIGNATURE Mrs. L. W. Bare

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 .....

Licensed Embalmer No. 4988

P. O. Address Stanhope

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.