

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-008886  
STATE FILE NUMBER

FILED APR 6 1959

Registration District No. 098 Primary Registration District No. Registrar's No. 35

100  
-57

1. PLACE OF DEATH a. COUNTY DAVIESS		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY DAVIESS	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN (RURAL) Colfax Twp		c. CITY OR TOWN RURAL (WINSTON)	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION AT HOME		d. STREET ADDRESS (If outside, give location) RURAL 4 MI. SW	
3. NAME OF DECEASED (Type or print) First Middle Last MARY AUGUSTA ROMIG		4. DATE OF DEATH Month Day Year 3-31-1959	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-27-1873
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY NONE	9. AGE (In years last birthday) 85
11. BIRTHPLACE (City and state or country) GRACE HILL, IOWA		12. CITIZEN OF WHAT COUNTRY? U.S.	
13a. FATHER'S NAME JOHN BUXBAUM		13b. MOTHER'S MAIDEN NAME MARY KOHLER	14. NAME OF HUSBAND OR WIFE BEN ROMIG
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO NO		16. SOCIAL SECURITY NO. NONE	17. INFORMANT Address HELEN MCGEHE, MANHATTEN, KAN
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) arterial sclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 321X			INTERVAL BETWEEN ONSET AND DEATH 60 hours Several years
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 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 March 28, 1959 to March 31, 1959 and last saw her alive on March 30, 1959. Death occurred at 6:00 p.m. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Fred Wilson MD		22b. ADDRESS Winston Mo	
22c. DATE SIGNED April 3, 59			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 4-3-1959	23c. NAME OF CEMETERY OR CREMATORY SHARON
23d. LOCATION (City, town, or county) GILMAN CITY MO		(State)	
24. FUNERAL DIRECTOR Mrs. Heas, Bethany Mo		25. DATE RECD. BY LOCAL REG. 4th Apr. 1959	26. REGISTRAR'S SIGNATURE Vigor Engelbert

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

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 *M. B. Haas* .....

Licensed Embalmer No. *3899* .....

P. O. Address. *Bethany, M* .....

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.