

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-013107
STATE FILE NUMBER

APR 28 1959 Registration District No. 140 Primary Registration District No. 3024 Registrar's No. 30

300
1-57

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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

1. PLACE OF DEATH a. COUNTY Howard		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Howard	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Fayette		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Fayette 0451
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Shields Boarding		Length of stay in lb 2 Years	d. STREET ADDRESS (If outside, give location) ----
3. NAME OF DECEASED (Type or print) First Sarah Middle Ethelene Last Cramer			4. DATE OF DEATH Month April Day 7 Year 1959
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 Oct. 20, 1863
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home	11. BIRTHPLACE (City and state or country) Indiana
13a. FATHER'S NAME Eli Stout.		13b. MOTHER'S MAIDEN NAME Rosetta Wilson.	14. NAME OF HUSBAND OR WIFE John Cramer.
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. -----	17. INFORMANT Address Mrs. Emil Stevens, New Franklin, 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) Pneumonia			INTERVAL BETWEEN ONSET AND DEATH 2 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			493X
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 _____ a.m. _____ p.m.		20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20e. CITY, TOWN, OR LOCATION		COUNTY	STATE
20f. CITY, TOWN, OR LOCATION		COUNTY	STATE
21. I attended the deceased from 1954 to April 7, 1959 and last saw her/him alive on April 7, 1959 Death occurred at 1:15 P.M. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE W. P. Leach, M.D.		22b. ADDRESS Fayette Mo	22c. DATE SIGNED 4-9-59
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE April 11, 1959	23c. NAME OF CEMETERY OR CREMATORY Ola Imine
23d. LOCATION (City, town, or county) Cooper County, Mo.		(State)	
24. FUNERAL DIRECTOR Goodman & Boller, Boonville, Mo.		25. DATE RECD. BY LOCAL REG. 4-9-59	26. REGISTRAR'S SIGNATURE Mary L. Shell

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 *William W. Wood*

Licensed Embalmer No. 4539

P. O. Address Boonville, 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.