

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-016235
STATE FILE NUMBER

FILED APR 27 1959 Registration District No. 37 Primary Registration District No. 590 Registrar's No. 1089

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1-57

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cause, manner, 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

1. PLACE OF DEATH a. COUNTY <u>ST. LOUIS, COUNTY</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>ILLINOIS</u> b. COUNTY <u>WILLIAMSON</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. JOHNS, MISSOURI</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>JOHNSTON CITY</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT an hospital, give location) HOSPITAL OR INSTITUTION <u>RUGL MANOR HOME</u>		Length of stay in 1b <u>2 YEARS</u>	d. STREET ADDRESS (If outside, give location) <u>907 BARHAM</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>MARTHA</u> Middle <u>ESTA</u> Last <u>WENTE</u>			4. DATE OF DEATH Month <u>April</u> Day <u>20</u> Year <u>1959</u>		
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT. 20, 1897</u>	9. AGE (In years last birthday) <u>81</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE IN HOME</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOUSEWIFE</u>	11. BIRTHPLACE (City and state or country) <u>NASHVILLE, ILLINOIS</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
13a. FATHER'S NAME <u>Williamas Huggins</u>		13b. MOTHER'S MAIDEN NAME <u>Molly Tree</u>		14. NAME OF HUSBAND OR WIFE <u>DECEASED</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	17. INFORMANT Address <u>Johnston City, Ill.</u> <u>MRS. Rosell Fehrbaker</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Hypertension</u>					INTERVAL BETWEEN ONSET AND DEATH
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"/> <u>2</u>
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.) <u>443X</u>			
20c. TIME OF INJURY Hour _____ a.m. _____ p.m.					
20d. INJURY OCCURRED WHILE AT <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 <u>Jan 1st</u> to <u>1958</u> and last saw her alive on <u>Apr 19th 59</u> Death occurred at <u>5:50 PM</u> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>N.A. Schumacher MD</u>			22b. ADDRESS <u>8863 Tudor ave</u>		22c. DATE SIGNED <u>4/21-59</u>
23a. NAME OF CEMETERY OR CREMATORY <u>BONITA</u>		23b. DATE <u>4/23/59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>NEW ROSE HILL CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>MARION, ILLINOIS</u>
24. FUNERAL DIRECTOR <u>MURMAN & Wilson</u>		ADDRESS <u>211 W. Broadway, Ill.</u>	25. DATE RECD. BY LOCAL REG. <u>4/21-59</u>	26. REGISTRAR'S SIGNATURE <u>John C. Murphy MD</u>	

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 *Frank Trokoff*

Licensed Embalmer No. *4356*

P. O. Address *H. Davis*

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.