

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS SEP 3 1959/60

59-029563

Registration District No. _____ Primary Registration District No. 3030 Registrar's No. 1Y9

STATE FILE NUMBER

| | | | |
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| 1. PLACE OF DEATH a. COUNTY <u>JEFFERSON</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO.</u> b. COUNTY <u>JEFFERSON</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>FESTUS, MO.</u> | | c. CITY OR TOWN <u>FESTUS, MO.</u> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>AT HOME</u> | | d. STREET ADDRESS (If outside, give location) <u>722 WARNE ST.</u> | |
| Length of stay in 1b | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |

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| 3. NAME OF DECEASED (Type or print) First <u>THERESIA</u> Middle <u>EMMA</u> Last <u>SEXAUER</u> | | | 4. DATE OF DEATH Month <u>AUG.</u> Day <u>24</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"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>5-11-81</u> | 9. AGE (last birthday) <u>78</u> | IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min. | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (City and state or country) <u>STE GENEVIEVE CO.</u> | | 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> | |
| 13a. FATHER'S NAME <u>SYLVESTER BRAUN</u> | | 13b. MOTHER'S MAIDEN NAME <u>MARY ECKENSELS</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>MRS. WILMA LUTKEY, HERCULANUM, MO.</u> | | | |

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| 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>Acute endocarditis</u> <u>Rheumatic fever</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) | | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | |

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| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input 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. 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 Apr 24, 59 to Aug 24, 59 and last saw her/him alive on Aug 24, 59
Death occurred at 11:17 P.M. on the date stated above, and to the best of my knowledge from the causes stated.

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| 22a. SIGNATURE <u>Dorothy D. [Signature]</u> (Degree or title) | | 22b. ADDRESS <u>Festus, Mo</u> | | 22c. DATE SIGNED <u>Aug 25, 59</u> (Date) |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u> | 23b. DATE <u>8-27-59</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>RESURRECTION</u> | 23d. LOCATION (City, town, or county) <u>ST. LOUIS COUNTY, MO.</u> | |

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| 24. FUNERAL DIRECTOR <u>James R. Cady - Crystal City, MO</u> | 25. DATE RECD. BY LOCAL REG. <u>8/25/59</u> | 26. REGISTRAR'S SIGNATURE <u>John N. Stoll Deputy</u> |
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

MS
SEP 11 1959

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of the certificate was embalmed by _____ or by _____, Student Embalmer No. _____ working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed James Richard Cady
Licensed Embalmer No. 43070

P. O. Address CRYSTAL CITY

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.

MAR 1 1960