

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED APR 26 1949

State File No. 11466

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

BIRTH NO. _____		REG. DIST. NO. <u>30</u>		PRIMARY REG. DIST. NO. <u>5104</u>		Registrar's No. <u>11</u>							
1. PLACE OF DEATH a. COUNTY <u>Benton</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE <u>Missouri</u> b. COUNTY <u>Benton</u>									
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rackett Rural Zone</u>		c. LENGTH OF STAY (in this place) <u>49</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rackett (Tom Township)</u>									
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Rackett Missouri</u>				d. STREET ADDRESS (If rural, give location) _____									
3. NAME OF DECEASED (Type or Print) a. (First) <u>Isaac</u>			b. (Middle) <u>(NONE)</u>		c. (Last) <u>Lionberger</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Apr. 13 1949</u>						
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>June 28, 1871</u>		9. AGE (In years last birthday) <u>77</u>		IF UNDER 1 YEAR Months <u>9</u> Days <u>15</u>		IF UNDER 24 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Self</u>		11. BIRTHPLACE (State or foreign country) <u>Ill.</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13a. FATHER'S NAME <u>Thomas Lionberger</u>				13b. MOTHER'S MAIDEN NAME <u>Sarah Tracey</u>				14. NAME OF HUSBAND OR WIFE <u>Mrs Sarah Lionberger</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>X</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs Sarah Lionberger Rackett, Mo</u>							
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure; ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Hemorrhage</u>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Cerebral Arteriosclerosis</u> DUE TO (c) <u>Diabetes Melitus</u>  II. OTHER SIGNIFICANT CONDITIONS <u>Diabetes</u> Conditions contributing to the death but not related to the disease or condition causing death.								INTERVAL BETWEEN ONSET AND DEATH <u>3 wks.</u> <u>ANK</u> <u>ANK</u>			
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____				21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____							
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____									
22. I hereby certify that I attended the deceased from <u>10 July</u> , 1948, to <u>March</u> , 1949, that I last saw the deceased alive on <u>March</u> , 1949, and that death occurred at <u>11:20 p.m.</u> , from the causes and on the date stated above.													
23a. SIGNATURE (Degree or title) <u>David H. Glenn, M.D.</u>						23b. ADDRESS <u>Warsaw, Mo.</u>			23c. DATE SIGNED <u>14 Apr 49</u>				
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Apr. 16, 1949</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Shady Grove</u>				24d. LOCATION (City, town, or county) (State) <u>Benton Mo.</u>					
DATE REC'D BY LOCAL REG. <u>17 Apr. 1949</u>		REGISTRAR'S SIGNATURE <u>Gas. A. Logan</u>				25. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Reese</u>		ADDRESS <u>Warsaw, Mo.</u>					

**RECEIVED**

District Health Officer N

District File Number 3-49

Date Filed 4-25-4

**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 .....  
Student Embalmer

Signed John F. Rosen

Licensed Embalmer No. 4098

P. O. Address Warsaw

**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 this body is not embalmed, fact should be so stated above.