

FILED JUL 29 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 24308

No. 300
10.4880
66
WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

BIRTH NO. _____		REG. DIST. NO. 274		PRIMARY REG. DIST. NO. 3052		Registrar's No. 244	
1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).			
a. COUNTY Pettis		b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Sedalia		c. LENGTH OF STAY (In this place) 59 yrs		a. STATE Missouri	
c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Sedalia		d. FULL NAME OF HOSPITAL OR INSTITUTION 826 W. 6th		d. STREET ADDRESS (If rural, give location) 826 W. 6th		b. COUNTY Pettis	
3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH (Month) (Day) (Year)				
a. (First) MARY	b. (Middle) SIGWART	c. (Last) HANSAW	July	19	1949		
5. SEX Female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED widowed	8. DATE OF BIRTH Feb-18-1864	9. AGE (In years last birthday) 85	if UNDER 1 YEAR Months 5	if UNDER 24 HRS. Days 1	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Lexington Mo		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Nicholas Sigwart		13b. MOTHER'S MAIDEN NAME Anna Belonger		14. NAME OF HUSBAND OR WIFE Edwin F. Hansam			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME Mrs. Edith Hansam			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Ac. Obstruction of Bowel				5 da	
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Carcinoma recto sigmoid 3 yrs					
		DUE TO (c)					
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				15X	
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) m.		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 April, 1946, to July 19, 1949, that I last saw the deceased alive on July 19, 1949, and that death occurred at 11:30 A.M., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) W. Boger M.D.				23b. ADDRESS Sedalia Mo		23c. DATE SIGNED 7-20-49	
24a. BURIAL / CREMATION, REMOVAL (Specify) Burial		24b. DATE July 20-49	24c. NAME OF CEMETERY OR CREMATORY Crown Hill		24d. LOCATION (City, town, or county) (State) Sedalia Mo		
DATE REC'D BY LOCAL REG. 7-20-49		REGISTRAR'S SIGNATURE Betty Yeager		25. FUNERAL DIRECTOR'S SIGNATURE McLaughlin Bros		ADDRESS Sedalia Mo	

Licensed Embalmer's Statement on Reverse Side

RECEIVED JUL 20

District Health Officer No. 8,

District File Number _____

Date Filed 7-27-49

REC-15 1956 51 57M

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.

Signed K.P.M. Crary

Signed _____
Student Embalmer

Licensed Embalmer No. 3153

P. O. Address Sadaleg N

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.

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