

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

28038

State File No. ....

FILED AUG 31 1953

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 66 PRIMARY REG. DIST. NO. 4116 Registrar's No. ....

|   |  |  |  |
|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Chariton</u>  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE <u>Mo</u> b. COUNTY <u>Chariton</u> |  |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Sumer</u> |  | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Sumer</u>  |  |
| c. LENGTH OF STAY (in this place)   |  | d. STREET ADDRESS (If rural, give location) <u>0210</u>  |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION   |  | d. STREET ADDRESS (If rural, give location) <u>0</u>   |  |

|                                     |                         |                      |                              |                                       |
|-------------------------------------|-------------------------|----------------------|------------------------------|---------------------------------------|
| 3. NAME OF DECEASED (Type or Print) | a. (First) <u>Sarah</u> | b. (Middle) <u>D</u> | c. (Last) <u>Thornsberry</u> | 4. DATE OF DEATH (Month) (Day) (Year) |
|                                     |                         |                      |                              | <u>Aug 22/53</u>                      |

|                 |                           |  |   |   |   |  |
|-----------------|---------------------------|--|---|---|---|--|
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u> | 8. DATE OF BIRTH <u>Feb'y 17th 1872</u> | 9. AGE (In years last birthday) <u>81</u> | IF UNDER 1 YEAR Months <u>6</u> Days <u>5</u> | IF UNDER 2 HRS. Hours <u></u> Min. <u></u> |
|-----------------|---------------------------|--|---|---|---|--|

|  |  |   |   |
|--|--|---|---|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | 10b. KIND OF BUSINESS OR INDUSTRY <u>Housework</u> | 11. BIRTHPLACE (State or foreign country) <u>Saline Co Mo</u> | 12. CITIZEN OF WHAT COUNTRY? <u>U S A</u> |
|--|--|---|---|

|  |  |  |
|--|--|--|
| 13a. FATHER'S NAME <u>Geo. Dummond</u> | 13b. MOTHER'S MAIDEN NAME <u>Mary Marrow</u> | 14. NAME OF HUSBAND OR WIFE <u>Mr William Thornsberry Sumer Mo</u> |
|--|--|--|

|  |                               |  |               |
|--|-------------------------------|--|---------------|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. _____ | 17. INFORMANT'S SIGNATURE OR NAME <u>Mr William Thornsberry Sumer Mo</u> | ADDRESS _____ |
|--|-------------------------------|--|---------------|

|   |   |  |                                  |
|---|---|--|----------------------------------|
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death. | MEDICAL CERTIFICATION   |  | INTERVAL BETWEEN ONSET AND DEATH |
|   | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Degenerative Nephroses</u>  |  | <u>5 years</u>                   |
|   | ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) <u>Acute Uremia</u><br>DUE TO (c) _____ |  | <u>4 days</u>                    |
| II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death.   |   |  |                                  |

|                        |  |   |
|------------------------|--|---|
| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION <u>5190</u> | 20. AUTOPSY? YES <input type="checkbox"/> NO <input 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 Aug 1948, 1948, to Aug 22, 1953, that I last saw the deceased alive on Aug 19, 1953, and that death occurred at 6:30 pm., from the causes and on the date stated above.

|  |                                   |                                 |
|--|-----------------------------------|---------------------------------|
| 23a. SIGNATURE <u>W B Simpson DR</u> (Degree or title) | 23b. ADDRESS <u>Brookfield Mo</u> | 23c. DATE SIGNED <u>8/24/53</u> |
|--|-----------------------------------|---------------------------------|

|   |                          |  |   |
|---|--------------------------|--|---|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 24b. DATE <u>8/24/53</u> | 24c. NAME OF CEMETERY OR CREMATORY <u>Lakeside</u> | 24d. LOCATION (City, town, or county) (State) <u>Sumer Mo</u> |
|---|--------------------------|--|---|

|   |  |   |                          |
|---|--|---|--------------------------|
| DATE REC'D BY LOCAL REG. <u>8/24/53</u> | REGISTRAR'S SIGNATURE <u>Maud WRIGHT</u> | 25. FUNERAL DIRECTOR'S SIGNATURE <u>S. L. Leisard</u> | ADDRESS <u>Wenden Mo</u> |
|---|--|---|--------------------------|

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

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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 \_\_\_\_\_

*S. L. Shepard*

Licensed Embalmer No. \_\_\_\_\_

*3970*

P. O. Address \_\_\_\_\_

*Mendon MA*

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.