

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

38434

FILED DEC 1-1953

State File No.
Registrar's No. 387

BIRTH NO. _____ REG. DIST. NO. 47 PRIMARY REG. DIST. NO. 5168

0140

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

1. PLACE OF DEATH a. COUNTY <u>Callaway</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Callaway</u>	
b. CITY (If outside corporate limits, write RURAL and give town) <u>Rural McCredie Twp</u>		c. CITY OR TOWN <u>McCredie</u>	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. LENGTH OF STAY (In this place) <u>70 years</u>		e. STREET ADDRESS (If rural, give location) <u>R.F.D.# 1</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Home</u>			

3. NAME OF DECEASED (Type or Print)	a. (First) <u>John</u>	b. (Middle) <u>Agustus</u>	c. (Last) <u>Sontag</u>	4. DATE OF DEATH (Month) (Day) (Year)
				<u>Nov 21 1953</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>Sept-9-1871</u>	9. AGE (In years last birthday) <u>82</u>	IF UNDER 1 YEAR Months <u>2</u>	IF UNDER 12 HRS. Days <u>12</u>	IF UNDER 1 MIN. Hours <u>0</u>
--------------------	-------------------------------	---	-------------------------------------	---	---------------------------------	---------------------------------	--------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired farmer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Franklin Co, Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
---	--	---	--

13a. FATHER'S NAME <u>Gus Sontag</u>	13b. MOTHER'S MAIDEN NAME <u>D.K.</u>	14. NAME OF HUSBAND OR WIFE <u>Jennie Dunn Sontag</u>
--------------------------------------	---------------------------------------	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>No</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Arthur Lewis, McCredie, Mo</u>	ADDRESS
---	--	--	---------

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, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>4 months</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Congestive heart failure</u>		
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>hypertension</u> DUE TO (c) <u>senility</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Recent Prostatectomy</u>			

18a. 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 6/17, 1957, to 11/21, 1953 that I last saw the deceased alive on 11/18, 1953 and that death occurred at 7A m., from the causes and on the date stated above.

23a. SIGNATURE <u>George F. Wood</u>	(Degree or title) <u>MD</u>	23b. ADDRESS <u>Fulton Mo</u>	23c. DATE SIGNED <u>11/24/53</u>
--------------------------------------	-----------------------------	-------------------------------	----------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>Nov-23-1953</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Callaway Memorial Garden</u>	24d. LOCATION (City, town, or county) (State) <u>Fulton Mo</u>
---	------------------------------	--	--

DATE REC'D BY LOCAL REG. <u>Nov-23-1953</u>	REGISTRAR'S SIGNATURE <u>Martha Lawrence</u>	426-0	25. FUNERAL DIRECTOR'S SIGNATURE <u>Wallace Funeral Home</u>	ADDRESS <u>Fulton Mo</u>
---	--	-------	--	--------------------------

(Licensed Embalmer's Statement on Reverse Side)

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 *William E. Fisher*.....

Licensed Embalmer No...*487*..

P. O. Address *Fulton*..

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.