

FILED AUG 29 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 27178

BIRTH NO. _____		REG. DIST. NO. <u>274</u>		PRIMARY REG. DIST. NO. <u>3052</u>		Registrar's No. <u>222</u>	
1. PLACE OF DEATH a. COUNTY <u>Pettis</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Pettis</u>			
b. CITY (If outside corporate limits, write RURAL and give town) <u>Sedalia</u>		c. LENGTH OF STAY (in this place) <u>6 wks</u>		c. CITY OR TOWN <u>Sedalia</u>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Bothwell Hospital</u>				STREET ADDRESS (If rural, give location) <u>1019 East 4th</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>AUGUSTA</u>		b. (Middle) <u>JOHANNA</u>		c. (Last) <u>HAHN</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Aug. 24, 1955</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Single</u>		8. DATE OF BIRTH <u>Feb. 15, 1880</u>	
9. AGE (In years last birthday) <u>75</u>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housekeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home-making</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Florence, Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>John Hahn</u>			13b. MOTHER'S MAIDEN NAME <u>Alice Hildebrandt</u>			14. NAME OF HUSBAND OR WIFE <u>*****</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Younger or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Otto Eldenburg, Florence, 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, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cardio-vascular Disease.</u> ANTECEDENT CAUSES <u>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</u> DUE TO (b) <u>Age and Arterio-Sclerosis.</u> DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS <u>Anemia, Secondary Epilepsy.</u> <u>Conditions contributing to the death but not related to the disease or condition causing death. Please see other side.</u>				INTERVAL BETWEEN ONSET AND DEATH <u>?</u> <u>?</u> <u>?</u>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION <u>Medical only.</u>				20. AUTOPSY? <u>4221</u> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>None.</u>		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) <u>None.</u>		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>Aug. 11th, 1955</u> , to <u>Aug. 24th, 1955</u> , that I last saw the deceased alive on <u>Aug. 24th, 1955</u> and that death occurred at <u>1:15 Pm.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Name or title) <u>Jno. B. Carlisle, M.D.</u>				23b. ADDRESS <u>Sedalia, Missouri</u>		23c. DATE SIGNED <u>Aug. 26th, 1955</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>8/26/55</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Union Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Florence, Missouri</u>	
DATE REC'D BY LOCAL REG. <u>8/24/55</u>		REGISTRAR'S SIGNATURE <u>Lorna Coontz</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Walter Gering</u>		ADDRESS <u>Sedalia, Mo.</u>	

(Licensed Embalmer's Statement on Reverse Side)

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

Dr. Carlisle

This lady was a patient of Dr.E.C.Snevley, Sedalia, Missouri. I cared for her during his being away on vacation. Accordingly I dont know all of the answers.

Dr. Carlisle- 8-26-55

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 *R. E. Baker*

Licensed Embalmer No. *24*
P. O. Address *Sedalia*

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