

FILED JUL 23 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **22908**

781

BIRTH NO. _____		REG. DIST. NO. 42		PRIMARY REG. DIST. NO. 1000		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY Buchanan				2. USUAL RESIDENCE (Where deceased lived). If institution: residence before admission) a. STATE Missouri b. COUNTY Buchanan			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Joseph		c. LENGTH OF STAY (In this place) 75 Yrs		c. CITY OR TOWN St. Joseph		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 2129 South 11th St.				e. STREET ADDRESS (If rural, give location) 2129 South 11th St.			
3. NAME OF DECEASED (Type or Print) a. (First) Sarah			b. (Middle) Mahaley		c. (Last) Sommerhauser		4. DATE OF DEATH (Month) (Day) (Year) July 17, 1956
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Dec. 29, 1871		9. AGE (In years last birthday) 84	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) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (City and State or Foreign Country) Meggs Co., Ohio		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME Louis Davis		13b. MOTHER'S MAIDEN NAME Sarah Selby		14. NAME OF HUSBAND OR WIFE Albert J. Sommerhauser			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs John T. Walsh St. Joseph Mo.			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.</i>		MEDICAL CERTIFICATION 1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Multiple Cerebral Hemorrhages ANTECEDENT CAUSES DUE TO (b) Generalized Arteriosclerosis <i>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</i> DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Senile Dementia and General Debility <i>Conditions contributing to the death but not related to the disease or condition causing death.</i> 331XF				INTERVAL BETWEEN ONSET AND DEATH Unk.	
19a. DATE OF OPERATION 2/18/56	19b. MAJOR FINDINGS OF OPERATION Fell in bathroom at 5:30a.m. on 2/13/56 at home fractured right hip. St. Joseph's Hospital.						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT, SUICIDE, HOMICIDE (Specify) accident		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) home		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) St. Joseph Buchanan Missouri			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) Feb 13, 1956 5:30A.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? fell in bathroom			
22. I hereby certify that I attended the deceased from 4/5 , 19 56 , to 7/17 , 19 56 , that I last saw the deceased alive on 7/17 , 19 56 , and that death occurred at 4:07pm. , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or Title) H. F. Mundy M.D.				23b. ADDRESS 2801 Sacramento St. St. Joseph, Mo.		23c. DATE SIGNED 7/18/56	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE July 20, 56	24c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		24d. LOCATION (City, town, or county) (State) St. Joseph, Mo.		
DATE REC'D BY LOCAL REG. July 20, 1956		REGISTRAR'S SIGNATURE Cather M. Allison		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Herman W. Sidenfaden St. Joseph, Mo.			

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

4850

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..... *Robert D. Gaylor*
Licensed Embalmer No. 3308

P. O. Address St. Joseph,

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.