

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

**THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH**

FILED JUL 24 1956

State File No. **22978**

BIRTH NO. _____		REG. DIST. NO. 47	PRIMARY REG. DIST. NO. 3008	Registrar's No. 190
1. PLACE OF DEATH a. COUNTY Callaway		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY FRANKLIN		
b. CITY (If outside corporate limits, write RURAL and give township) Fulton Mo.		c. LENGTH OF STAY (In this place) 15Y-2M-0D	c. CITY OR TOWN Union Mo.	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 State Hospital #1		e. STREET ADDRESS (If rural, give location) None		
3. NAME OF DECEASED a. (First) Augusta		b. (Middle) _____	c. (Last) Beisgenharz	4. DATE OF DEATH (Month) (Day) (Year) July 16 1956
5. SEX Female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH Aug. 4, 1869	9. AGE (In years last birthday) 86
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY HOME	11. BIRTHPLACE (City and State or Foreign Country) Washington Missouri	
12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME D. K.		
13b. MOTHER'S MAIDEN NAME D. K.		14. NAME OF HUSBAND OR WIFE None		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. D.K.	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Hospital Records Fulton Mo.	
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Thrombosis		INTERVAL BETWEEN ONSET AND DEATH
		ANTECEDENT CAUSES DUE TO (b) Myocarditis		
		DUE TO (c) Chronic Nephritis		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				
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) 592x		
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	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 JUNE 1, 1956 to July 16, 1956 , that I last saw the deceased alive on July 16, 1956 , and that death occurred at 6 P.M. , from the causes and on the date stated above.				
23a. SIGNATURE (Degree or title) Ralph Hanko MD		23b. ADDRESS Fulton Mo.		23c. DATE SIGNED July 16, 1956
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 7-19-56	24c. NAME OF CEMETERY OR CREMATORY anatomical board	24d. LOCATION (City, town, or county) (State) Columbia Mo	
DATE REC'D BY LOCAL REG. July-19-1956	REGISTRAR'S SIGNATURE Maretha Lawrence	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS J. O. Roberts Columbia Mo		

(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.....

Licensed Embalmer No.....

P. O. Address

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.