

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

16027

STATE FILE NUMBER

FILED APR 29 1957

Registration District No. 375 Primary Registration District No. 6279 Registrar's No. 8

Health,
& Welfare
Public
Service

300
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY <u>Wright</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>Wright</u>						
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>GASCONADE</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN <u>Hartville 1140</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>				
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Hartville Rt 2</u>			Length of stay in 1b <u>31 YEARS</u>		d. STREET ADDRESS (If outside, give location) <u>Rt 2</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>Henry</u> Last <u>Sternberg</u>				4. DATE OF DEATH Month <u>APRIL</u> Day <u>6</u> Year <u>1957</u>						
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 1, 1893</u>	9. AGE (In years last birthday) <u>63</u>	IF UNDER 1 YEAR Month <u>7</u> Days <u>5</u> Hours <u></u> Min. <u></u>	IF UNDER 24 HRS. Hour <u></u> Min. <u></u>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>	100. KIND OF BUSINESS OR INDUSTRY <u>FARMING</u>	11. BIRTHPLACE (City and state or country) <u>Wright County Mo.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>William H. Sternberg</u>				14. MOTHER'S MAIDEN NAME <u>Della Merritt</u>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>			16. SOCIAL SECURITY NO. <u>Neb. Nat'l Guard 500-40-9300</u>		17. INFORMANT <u>Ethel Sternberg</u>		Address <u>Hartville Mo</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO (b) <u>Arteriosclerosis</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____								INTERVAL BETWEEN ONSET AND DEATH <u>one yr 18 months</u>		
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20c. TIME OF INJURY Hour _____ Month _____ Day _____ a. m. _____ p. m. _____										
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY		STATE		
21. I attended the deceased from <u>April 1 - 1956</u> to <u>April 6 - 1957</u> and last saw her/him alive on <u>Mar 20 - 1957</u> Death occurred at <u>9-15 PM</u> m on the date stated above; and to the best of my knowledge, from the causes stated.										
22a. SIGNATURE (Degree or title) <u>J. R. Smith M.D.</u>				22b. ADDRESS <u>Hartville Mo</u>		22c. DATE SIGNED <u>4-15-57</u>				
23a. RITUAL CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>4-9-57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>SEYMOUR</u>		23d. LOCATION (City, town, or county) <u>SEYMOUR</u>		(State) <u>MO.</u>			
24. FUNERAL DIRECTOR ADDRESS <u>Max & Miller Monroeville Mo</u>			25. DATE RECD. BY LOCAL REG. <u>4-15-1957</u>		26. REGISTRAR'S SIGNATURE <u>Bonnie J. Jones</u>					

(Licensed Embalmer's Statement on Reverse Side)

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RECEIVED 4-18-57
 WRIGHT CO. HEALTH DEPT.
 County File Number 4-57-42
 Date Filed 4-18-57

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 *Max J. Miller*

Licensed Embalmer No. *472*

P. O. Address *Manfield*

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.