

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

32376

STATE FILE NUMBER

FILED OCT 1 1957

Registration District No. 156 Primary Registration District No. 2001 Registrar's No. 452

1. PLACE OF DEATH a. COUNTY <u>JASPER</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>KANSAS</u> b. COUNTY <u>CHEROKEE</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) Inside Limits OR TOWN <u>JOPLIN</u> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>GALENA</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>St. John's Hospital</u> Length of stay in 1b <u>6 DAYS</u>		d. STREET ADDRESS (If outside, give location) <u>RR. #1 Box 67</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) <u>AMANDA DELLA SULLENGER</u> First Middle Last			4. DATE OF DEATH <u>Sept. 23 1957</u> Month Day Year		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 18, 1883</u>	9. AGE (In years last birthday) <u>74</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	11. BIRTHPLACE (City and state or country) <u>Newberg Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>George Cavett</u>			14. MOTHER'S MAIDEN NAME <u>MARY Sexton</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>515-05-9729</u>	17. INFORMANT <u>John SULLENGER</u> Address <u>Galena Kansas</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>Pulmonary Embolus</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Just 10 hrs.</u>
Conditions, if any, which gave rise to above - cause (a), stating the underlying cause last.	DUE TO (b) <u>Post-Cholecystectomy</u>	
	DUE TO (c) <u>586x</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Hypertensive Cardiovascular Disease</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>

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.)	
20c. TIME OF INJURY Hour Month, Day, Year 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 1947 to 23 Sept 1957 and last saw her alive on 23 Sept 57
Death occurred at 10:40 p. m. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Robert Paul M.D.</u>	22b. ADDRESS <u>Galena, Kansas</u>	22c. DATE SIGNED <u>24 Sept 57</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>9-27-57</u>	23b. DATE <u>9-27-57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Oak Hill Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Galena Kansas</u>
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24. FUNERAL DIRECTOR ADDRESS <u>Roy L. Derfelt Galena Kansas</u>	25. DATE RECD. BY LOCAL REG. <u>9-24-1957</u>	26. REGISTRAR'S SIGNATURE <u>Wood Merriam</u>
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(Licensed Embolmer's Statement on Reverse Side)

health, Welfare Public Service
 300 1-56
 All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.
 Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

526

County File No. 57-9-887
Date Filed SEP 30 1957
Health Office

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, DERFELT FUNERAL HOME, Student Embalmer No. _____, working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Roy L. Derfelt

Licensed Embalmer No. 494

P. O. Address Galena, Ill.

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.