

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

41402

FILED DEC 9 - 1957

STATE FILE NUMBER

Registration District No. 274 Primary Registration District No. 3052 Registrar's No. 21

S. 300
v. 1-57

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. **GILLESPIE FUNERAL HOME**

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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, give TOWNSHIP only) OR <u>Sedalia</u> TOWN		c. CITY OR TOWN <u>Sedalia</u>	
Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>651 E. 14th, St.</u>		Length of stay in lb <u>38 Yrs.</u>	
d. STREET ADDRESS <u>651 East 14th., St.</u>		(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>OTTO</u> Middle <u>H.</u> Last <u>EDING</u>		4. DATE OF DEATH <u>December 2, 1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 28, 1889</u>
9. AGE (In years at birthday) <u>68</u>		10. UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	11. UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Painter-Mechanic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>M.K.T. Railroad</u>	
11. BIRTHPLACE (City and state or country) <u>Mt. Hulda, Benton Co., Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>Herman Eding</u>		13b. MOTHER'S MAIDEN NAME <u>Mary Pohl</u>	
14. NAME OF HUSBAND OR WIFE <u>Pauline Eckhoff Eding</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs. Pauline Eding, Sedalia, Missouri</u>		Address	
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>Cerebral Hemorrhage</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden Death</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Hypertensive Cardio-Vascular Disease</u>		<u>1 year</u>	
DUE TO (c) <u>Arteriosclerotic Heart Disease</u>		<u>3 year</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>4200</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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 <u>October 23, 1957</u> to <u>December 2, 1957</u> and last saw <u>him</u> alive on <u>October 23, 1957</u> Death occurred at <u>10:25 A</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Stanley D. Fisher MD</u> (Degree or title)		22b. ADDRESS <u>500 1/2 So Ohio, Sedalia, Missouri</u>	
		22c. DATE SIGNED <u>3 December 57</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>12/4/1957</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Sedalia, Missouri</u>	
24. FUNERAL DIRECTOR <u>D. W. Heckart, Sedalia, Missouri</u>		ADDRESS	
25. DATE RECD. BY LOCAL REG. <u>12-4-57</u>		26. REGISTRAR'S SIGNATURE <u>Frances Shelby</u>	

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STATE OF MISSOURI
DEPARTMENT OF HEALTH

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 *Russell C. Maag*

Licensed Embalmer No. *4804*

P. O. Address *Sedalia, Mo*

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.