

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

882

STATE FILE NUMBER

FILED JAN 27 1958

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 64

1. PLACE OF DEATH a. COUNTY <u>GREENE</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>GREENE</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>SPRINGFIELD</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>SPRINGFIELD</u> 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>BURJE</u> Length of stay in 1b <u>2 HRS</u>		d. STREET ADDRESS (If outside, give location) <u>1307 E. PACIFIC</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>SARAH BUMGARNER</u>			4. DATE OF DEATH Month Day Year <u>JAN 18 1958</u>
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>FEB 14 1909</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		9b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	9. AGE (In years last birthday) <u>48</u> IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.
10a. FATHER'S NAME <u>JOSEPH BRYANT</u>		11. BIRTHPLACE (City and state or country) <u>MISSOURI</u>	
10b. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
16. SOCIAL SECURITY NO. <u>—</u>		14. MOTHER'S MAIDEN NAME <u>SARAH LANE</u>	
17. INFORMANT <u>THOMAS BUMGARNER, SPRINGFIELD</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>Massive Pulmonary Embolism</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 HRS.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>PELVIC VEIN THROMBOSIS</u> <u>633X</u>			
DUE TO (c) <u>POST OP HYSTERECTOMY & A/P Repair</u>			<u>9 DAYS.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Cholecystitis with lithiasis, Diabetes Mellitus</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 checked="" 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>30 Dec. '57</u> to <u>18 Jan. '58</u> and last saw <u>her</u> alive on <u>18 Jan. 1958</u> Death occurred at <u>7:40</u> p. m. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>W. R. Koby M.D.</u> (Degree or title)		22b. ADDRESS <u>Springfield, Mo.</u>	22c. DATE SIGNED <u>21 Jan. '58</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>1-22-1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>WELCH</u>	23d. LOCATION (City, town, or county) (State) <u>WEBSTER CO MO</u>
24. FUNERAL DIRECTOR <u>BARBER-EDWARDS MARSHFIELD</u> ADDRESS	25. DATE RECD. BY LOCAL REG. <u>1-22-58</u>	26. REGISTRAR'S SIGNATURE <u>Effie G. Melton</u>	

(Licensed Embalmer's Statement on Reverse Side)

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

MEDICAL CERTIFICATION

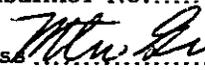
STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was e
by me, or by, Student Embalmer No.....
working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed.....


Licensed Embalmer No. 3

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.