

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-012856
STATE FILE NUMBER

FILED APR 11 1958

Registration District No. 333 Primary Registration District No. 3074 Registrar's No. 58

| | | | | | |
|---|----------------------------------|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Scott | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Scott | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Sikeston | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN Sikeston | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Mo. Delta Community Hospital-100 | | | Length of stay in 1b 100 Days | | STREET ADDRESS Route #1 (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First Bertilla Middle Regina Last Pobst | | | 4. DATE OF DEATH Month 3 Day 31 Year 1958 | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> / DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 6-22-1915 | 9. AGE (In years last birthday) 42 | IF UNDER 1 YEAR Months _____ Days _____ IF UNDER 24 HRS. Hours _____ Min. _____ |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY — | | 11. BIRTHPLACE (City and state or country) Oran, Missouri | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | | 13. FATHER'S NAME John Dohogne | | |
| 14. MOTHER'S MAIDEN NAME Laura Dirnberger | | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | |
| 16. SOCIAL SECURITY NO. | | | 17. INFORMANT Arthur Pobst, Sikeston, Mo. | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Brain tumor ± Metastasis | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | | | | DUE TO (b) _____ DUE TO (c) _____ |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | 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.) 2 | | |
| 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 | | 20g. COUNTY STATE | |
| 21. I attended the deceased from 12-24-57 to 3-31-58 and last saw her alive on 3-31-58 Death occurred at 1:25 P. m on the date stated above; and to the best of my knowledge, from the causes stated. | | | | | |
| 22a. SIGNATURE (Degree or title) Alben B. Sargent M.D. | | | 22b. ADDRESS Sikeston, Mo. | | 22c. DATE SIGNED 4-1-58 |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE April 2 1958 | | 23c. NAME OF CEMETERY OR CREMATORY New Guardian Angels | |
| 23d. LOCATION (City, town, or county) Oran | | 23e. STATE Mo. | | | |
| 24. FUNERAL DIRECTOR Calvin [Signature] | | ADDRESS Oran, Mo. | | 25. DATE RECD. BY LOCAL REG. 4-4-58 | |
| 26. REGISTRAR'S SIGNATURE Miss [Signature] | | | | | |

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

DATE RECEIVED APR 7 1958

SCOTT CO. HEALTH DEPT.

CO. FILE No. 458-86

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 *Earl J. Smith*

Licensed Embalmer No. *26*

P. O. Address *Orean,*

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.