

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-014781
STATE FILE NUMBER

FILED APR 22 1958 Registration District No. 164 Primary Registration District No. 3032 Registrar's No. 57

300
1-57

0513

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY Johnson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Lafayette	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Warrensburg		c. CITY OR TOWN Higginsville	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Warrensburg Med Center		d. STREET ADDRESS (If outside, give location) 207 East 14th.	
3. NAME OF DECEASED (Type or print) Sharon Ann Maring		4. DATE OF DEATH Month 4 Day II Year 1958	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 4, 1948
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School		11. BIRTHPLACE (City and state or country) Warrensburg, Mo.	12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME Clifford J. Maring		13b. MOTHER'S MAIDEN NAME Ruth Luetjen	14. NAME OF HUSBAND OR WIFE none
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	17. INFORMANT Clifford Maring Address Higginsville, 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) acute leukemia			INTERVAL BETWEEN ONSET AND DEATH 6 mths
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			2043
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.)	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____			
20d. INJURY OCCURRED WHILE AT <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 June 1954 to 11 April 58 and last saw her alive on 11 April 58 . Death occurred at 5:30 PM on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) T. Reed Maxson M.D.C.		22b. ADDRESS Warrensburg Mo	
		22c. DATE SIGNED 16 April 58	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 4-II-58	
		23c. NAME OF CEMETERY OR CREMATORY City	
		23d. LOCATION (City, town, or county) (State) Higginsville, Mo.	
24. FUNERAL DIRECTOR F. A. Hofer		25. DATE RECD. BY LOCAL REG. Apr. 16, 1958	
		26. REGISTRAR'S SIGNATURE Savannah Crutcher	

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 *Ernest R. Hofer*
480I

Licensed Embalmer No.
P. O. Address Higginsville, 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.