

Dr. Langston

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-021623  
STATE FILE NUMBER

FILED JUN 23 1958 Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 635

300  
-57

1. PLACE OF DEATH a. COUNTY <b>GREENE</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>GREENE</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>SPRINGFIELD</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>SPRINGFIELD</b> 63960
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>MERCY HOSP.</b>		Length of stay in 1b <b>70 YRS.</b>	d. STREET ADDRESS (If outside, give location) <b>1101 NICHOLS</b>
3. NAME OF DECEASED (Type or print) First Middle Last <b>BARBARA M. SAYER</b>		4. DATE OF DEATH Month Day Year <b>JUNE 18 1958</b>	

5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>SEPT. 30 1874</b>	9. AGE (In years less birthday) <b>83</b>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOME</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>ILLINOIS</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
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13a. FATHER'S NAME <b>JACOB BOLL</b>	13b. MOTHER'S MAIDEN NAME <b>MARY DIDEL</b>	14. NAME OF HUSBAND OR WIFE <b>ANTHONY SAYER (DEC.)</b>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) (If yes, give war or dates of service) <b>NO</b>	16. SOCIAL SECURITY NO. <b>NO</b>	17. INFORMANT Address <b>BERNARD &amp; LEO SAYER SPRINGFIELD, MO</b>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>metastatic carcinoma of lung - primary of breast</i> DUE TO (b) <i>Cerebral Hemorrhage</i> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <i>Jan. 1957</i> <i>6/14/58</i> <b>170X</b>
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.)
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20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	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
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21. I attended the deceased from Death occurred at <i>1948</i> to <i>6/18/58</i> and last saw her <i>6/7/58</i> alive on _____ 5:30 A.M. _____ m on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE (Degree or title) <i>W. Roland Langston M.D.</i>	22b. ADDRESS <i>Springfield</i>	22c. DATE SIGNED <i>6/18/58</i>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>6/20/58</b>	23c. NAME OF CEMETERY OR CREMATORY <b>ST. MARY'S CEMETERY</b>	23d. LOCATION (City, town, or county) (State) <b>SPRINGFIELD, MO.</b>
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24. FUNERAL DIRECTOR <b>H.H. LOHMEYER</b>	ADDRESS <b>SPRINGFIELD, MO.</b>	25. DATE RECD. BY LOCAL REG. <b>6-19-58</b>	26. REGISTRAR'S SIGNATURE <i>Effie G. Melton</i>
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 *A.H. McCann* .....

Licensed Embalmer No. *2727* .....  
P. O. Address *Spokane, W.A.* .....

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.