

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-029840
STATE FILE NUMBER

FILED SEP 2 1958 Registration District No. 772 Primary Registration District No. 4398 Registrar's No. 27

1. PLACE OF DEATH a. COUNTY <u>Democrat</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Democrat</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Hallond</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <u>Hallond</u> 6150
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		Length of stay in 1b	d. STREET ADDRESS (If outside, give location)
			Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Henretta</u> Middle <u>Hause</u> Last <u>Hause</u>			4. DATE OF DEATH Month <u>Aug.</u> Day <u>12</u> Year <u>1958</u>		
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5. SEX <u>F</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-23-1879</u>	9. AGE (In years last birthday) <u>79</u> Months <u>6</u> Day <u>19</u> Hours <u></u> Min. <u></u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home work</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Hidson Mo</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13a. FATHER'S NAME <u>Andy Sternitt</u>	13b. MOTHER'S MAIDEN NAME <u>Mary Basinger</u>	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO.	17. INFORMANT <u>E. J. Hause</u> Address <u>Hallond Mo</u>
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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) <u>Dehydration</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6000</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Pyelonephritis</u>	
	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.)
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20c. TIME OF INJURY Hour <u></u> Month <u></u> Day <u></u> Year <u></u> a.m. <u></u> p.m. <u></u>	20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> 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 <u>8/10/58</u> to <u>8/11/58</u> and last saw her/him alive on <u>8/11/58</u> . Death occurred at <u>12:25 P</u> m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u> Cecil E. Halcomb, M.D.</u> (Degree or title)	22b. ADDRESS <u>Stule, Mo.</u>	22c. DATE SIGNED <u>8/18/58</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <u>8-12-58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Zion</u>	23d. LOCATION (City, town, or county) (State) <u>Stule Mo</u>
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24. FUNERAL DIRECTOR <u>Herman Todd Co.</u> ADDRESS <u>Stule Mo</u>	25. DATE RECD. BY LOCAL REG. <u>8-23-58</u>	26. REGISTRAR'S SIGNATURE <u>[Signature]</u>
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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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

AUG 29 1930

CARUTHERSVILLE, MO.

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 *Noel C. Dean*

Licensed Embalmer No. *3946*
P. O. Address *Caruthersville*

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.