Health, Welfare & Public Service

300
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-042915
STATE FILE NUMBER

FILED DEC 8 1958 Registration District No. 319 Primary Registration District No. 6079 Registrar's No. 77

1. PLACE OF DEATH
a. COUNTY St. Genevieve Mo.
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN — Inside Limits Yes ☐ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) Rural RT. 2 — Length of stay in Hospital 3Years

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo. b. COUNTY St Genevieve Mo
c. CITY OR TOWN Rural RT. 2 0750 St. Genevieve — Inside Limits Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location) Rural RT. — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First: Bertha Middle: M. Last: Hayes

4. DATE OF DEATH Month 12 Day 4 Year 58

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 6/19/1895
9. AGE (In years last birthday): 63 — 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): House Wife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (City and state or country): Clinton Mo.
12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: John L. Bozarth
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service): ********
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Mrs Lucille MC Donald — Address: St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Chronic Myo Carditis — INTERVAL BETWEEN ONSET AND DEATH: 1 yr
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): 4222

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 WORK ☐ NOT WHILE AT WORK ☐
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 Dec 4th to Dec 4th and last saw her/him alive on Dec 4th
Death occurred at Dec 4 1958 on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Arthur Eberhauer M.D.
22b. ADDRESS: St. Genevieve Mo
22c. DATE SIGNED: 12/5/58

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 12/8/58
23c. NAME OF CEMETERY OR CREMATORY: Crown Hill Cemetery
23d. LOCATION (City, town, or county): Sedalia (State): Mo.

24. FUNERAL DIRECTOR: Politte Funeral Home Crystal City — ADDRESS
25. DATE RECD. BY LOCAL REG.: Dec. 5, 1958
26. REGISTRAR'S SIGNATURE: Lucille O Barler

(Licensed Embalmer's Statement on Reverse Side)

SEP 10 1962

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was em

by me, or by ....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed.....

Licensed Embalmer No. 34

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.