

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-004709
STATE FILE NUMBER

FILED MAR 2 1959 Registration District No. 47 Primary Registration District No. 3008 Registrar's No. 55

300
1-57

2

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

1. PLACE OF DEATH a. COUNTY <u>Callaway</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Cole</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Fulton</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Henley</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>State Hospital #37</u>		Length of stay in hospital <u>37 months</u>	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 Middle Last <u>JOHN SESTAK</u>			4. DATE OF DEATH Month Day Year <u>Feb. 23 1959</u>
5. SEX <u>male</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>June 18-1869</u>
9. AGE (In years last birthday) <u>89</u>		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) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>	11. BIRTHPLACE (City and state or country) <u>Chicago Illinois</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13a. FATHER'S NAME <u>Albert Sestak</u>	
13b. MOTHER'S MAIDEN NAME <u>Unknown</u>		14. NAME OF HUSBAND OR WIFE	
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. <u>OK</u>	17. INFORMANT Address <u>State Hosp #1 Records, Fulton, Mo</u>
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>Coronary Thrombosis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>arteriosclerosis</u> DUE TO (c) <u>Chronic Brain Syndrome</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>42c1</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 Month, Day, Year a.m. p.m.		20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20e. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21. Date of death <u>Jan. 13, 1956</u> to <u>Feb. 23, 1959</u> and last saw her alive on <u>Feb. 23, 1959</u> Death occurred at <u>5:42 P.M.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.		21. Date of death <u>Jan. 13, 1956</u> to <u>Feb. 23, 1959</u> and last saw her alive on <u>Feb. 23, 1959</u> Death occurred at <u>5:42 P.M.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE (Degree or title) <u>Dr. J. Francis M.D.</u>		22b. ADDRESS <u>State Hospital</u>	
22c. DATE SIGNED <u>2-23-59</u>		22c. DATE SIGNED <u>2-23-59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>Feb. 25-1959</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Campbell</u>		23d. LOCATION (City, town, or county) (State) <u>Russellville Mo</u>	
24. FUNERAL DIRECTOR <u>B N. Stephen Russell</u>		25. DATE RECD. BY LOCAL REG. <u>Feb. 23-1959</u>	
26. REGISTRAR'S SIGNATURE <u>Maretha Lawrence</u>		26. REGISTRAR'S SIGNATURE <u>Maretha Lawrence</u>	

65617
MAR

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 *G. N. Steffen*

Licensed Embalmer No. *2307*

P. O. Address *Russellville, 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.