

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-009214

STATE FILE NUMBER

Registration District No. 382 Primary Registration District No. 4230 Registrar's No. 7

1. PLACE OF DEATH a. COUNTY <u>Howard</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Randolph</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Armstrong</u>		c. CITY OR TOWN <u>Moberly</u> ⁰⁸⁸³ ₀	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Pierce Nursing Home</u>		d. STREET ADDRESS (If outside, give location) <u>820 W. Reed St.</u>	
Length of stay in lb <u>1 Yr.</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>SARAH</u> Middle <u>JOSEPHINE</u> Last <u>WEIS</u>			4. DATE OF DEATH Month <u>MAR.</u> Day <u>26</u> Year <u>1959</u>		
--	--	--	--	--	--

5. SEX <u>Female</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>May 26, 1861</u>	9. AGE (In years last birthday) <u>97</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
-------------------------	----------------------------------	---	---	--	--	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Armstrong, Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
---	-----------------------------------	--	--

13a. FATHER'S NAME <u>Wm. Green Evans</u>	13b. MOTHER'S MAIDEN NAME <u>Ammosette Hardin</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) <u>NO</u>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT <u>P. K. Weis, Sr.</u>	Address <u>Moberly</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>Right hemiplegia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>unknown</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Essential hypertension</u>	
	DUE TO (c) _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (e) <u>334X</u>		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 _____ 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 _____
---	--	--

21. I attended the deceased from July 1 58 to March 26 1959 and last saw her alive on March 25 1959. Death occurred at 4:00 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Annis J. Dem</u> (Degree or title) <u>MD</u>	22b. ADDRESS <u>Payette, Mo</u>	22c. DATE SIGNED <u>3-30-59</u>
---	------------------------------------	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Mar. 28, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Oakland</u>	23d. LOCATION (City, town, or county) (State) <u>Moberly Missouri</u>
--	-----------------------------------	--	--

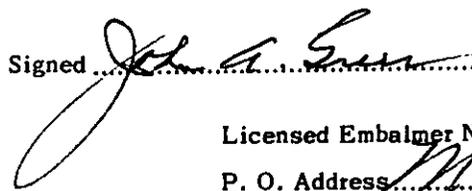
24. FUNERAL DIRECTOR <u>Mahan Funeral Service</u>	ADDRESS <u>Moberly</u>	25. DATE RECD. BY LOCAL REG. <u>Mar. 31, 1959</u>	26. REGISTRAR'S SIGNATURE <u>Walker Andsley</u>
--	---------------------------	--	--

All diseases in Part I must be causally related. USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE. MEDICAL CERTIFICATION

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 
Licensed Embalmer No. 2815
P. O. Address Moberly

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.