

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-010590

STATE FILE NUMBER

FILED APR 14 1959

Registration District No. 310 Primary Registration District No. 3058 Registrar's No. 92

300  
-57

1. PLACE OF DEATH a. COUNTY <b>St Charles</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>St Louis</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St Charles</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>St Ann</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St Joseph Hospital</b>		Length of stay in 1b <b>15 Da.</b>	d. STREET ADDRESS (If outside, give location) <b>3601 Long Drive</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>EMMA</b> Middle <b>FRANCIS</b> Last <b>SONNER</b>			4. DATE OF DEATH Month <b>April</b> Day <b>6</b> Year <b>1959</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>April 23, 1875</b>	
9. AGE (In years (last birthday)) <b>83</b>	IF UNDER 1 YEAR Month <b>11</b> Days <b>13</b>	IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Housework</b>		11. BIRTHPLACE (City and state or country) <b>Hawkpoint MO.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					
13a. FATHER'S NAME <b>Richard Giles</b>		13b. MOTHER'S MAIDEN NAME <b>Mildred Barlow</b>		14. NAME OF HUSBAND OR WIFE <b>Marion Sonner</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>None</b>	16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT <b>Gola Gordon</b>		Address <b>Hawkpoint MO.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>tumor of left lung probable carcinoma</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) <b>16.3x</b>					INTERVAL BETWEEN ONSET AND DEATH <b>3 day</b> <b>6 mo</b>
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 a.m. p.m. Month, Day, Year					
20d. INJURY OCCURRED WHILE AT WORK <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 <b>Jan 1956</b> to <b>April 6, 1959</b> and last saw her alive on <b>April 6, 1959</b> Death occurred at <b>1.12 P. m</b> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <b>W. J. Paffenhofer MD</b>			22b. ADDRESS <b>St Charles, Mo</b>		22c. DATE SIGNED <b>April 8, 1959</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>April 8, 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Hawkpoint Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Hawkpoint Missouri</b>	
24. FUNERAL DIRECTOR <b>D. M. Coy</b>		ADDRESS <b>Tracy Mo</b>	25. DATE RECD. BY LOCAL REG. <b>APR 8 59</b>	26. REGISTRAR'S SIGNATURE <b>Marcella Wilson</b>	

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 ..... *D. W. McEly* .....

Licensed Embalmer No. *3586* .....

P. O. Address *Tracy, 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.