

Health,  
Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-016584

FILED MAY 11 1959

Registration District No. 373

Primary Registration District No. 6269

STATE FILE NUMBER

Registrar's No. 25

300  
-57

1. PLACE OF DEATH a. COUNTY <b>WEBSTER</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before 6 months) a. STATE <b>MO</b> b. COUNTY <b>WEBSTER</b>	
b. CITY OR TOWN <b>OSARK</b> (If outside corporate limits, give TOWNSHIP only) Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN <b>MARSHFIELD R2</b> 1120 Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		d. STREET ADDRESS (If outside, give location) <b>4 mi S.W.</b> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <b>LIZZIE</b> Middle <b>LEHENBAUER</b> Last			4. DATE OF DEATH <b>APR 22 1959</b> Month Day Year		
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5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>2 WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></b>	8. DATE OF BIRTH <b>OCT 11 1872</b>	9. AGE (In years at birthday) <b>86</b>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min.
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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	11. BIRTHPLACE (City and state or country) <b>GERMANY 4</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>
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13a. FATHER'S NAME <b>GEORGE DORNES</b>	13b. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>	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) <b>NO</b>	16. SOCIAL SECURITY NO.	17. INFORMANT <b>ROBERT LEHENBAUER MARSHFIELD R2</b> Address
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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) <b>PULMONARY CONGESTION</b>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>CEREBRAL THROMBOSIS</b>	
	DUE TO (c) <b>ARTERIOSCLEROSIS</b>	

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"/>
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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 a.m. Month, Day, Year p.m.	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
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21. I attended the deceased from <b>1-15-59</b> to <b>4-22-59</b> and last saw <b>her</b> alive on <b>4-21-59</b> Death occurred at <b>5:30 A.M.</b> on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE <b>[Signature]</b> (Degree or title) <b>MD.</b>	22b. ADDRESS <b>Marshfield, Mo.</b>	22c. DATE SIGNED <b>4/25/59</b>
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23a. BURIAL, CREMATION, or REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>4-24-59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>MARSHFIELD</b>	23d. LOCATION (City, town, or county) (State) <b>MARSHFIELD MO</b>
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24. FUNERAL DIRECTOR <b>BARBER-EDWARDS</b> ADDRESS <b>MARSHFIELD</b>	25. DATE RECD. BY LOCAL REG. <b>5/2/59</b>	26. REGISTRAR'S SIGNATURE <b>[Signature]</b>
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All diseases in Part I must be causally related.

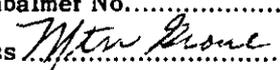
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

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. ....  
P. O. Address  .....

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.