

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-018407

STATE FILE NUMBER

Registrar's No. 97

FILED JUN 1 1959

Registration District No. 200

Primary Registration District No. ~~200~~

1. PLACE OF DEATH a. COUNTY <b>Macon</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR <b>Lydia Township</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <b>Independence</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>R.R. At lanta</b>		Length of stay in lb.	7003 d. STREET ADDRESS (If outside, give location) <b>19106 Truman Rod</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>LYDIA</b> Middle Last <b>DREISBACH</b>			4. DATE OF DEATH Month <b>May</b> Day <b>17</b> Year <b>1959</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 1, 1876</b>	9. AGE (In years last birthday) <b>82</b>	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) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	11. BIRTHPLACE (City and state or country) <b>Arthur, Illinois</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>
13a. FATHER'S NAME <b>Unknown Taylor</b>		13b. MOTHER'S MAIDEN NAME <b>Unknown</b>		14. NAME OF HUSBAND OR WIFE <b>Joseph F. Dreisbach</b>	
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. <b>None</b>	17. INFORMANT <b>Joseph F. Dreisbach, 19106 Truman Rd., Indep. 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>Body Completely Crushed</b>					INTERVAL BETWEEN ONSET AND DEATH <b>Inst.</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>Plane Crash</b>					866X
DUE TO (c)					
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"/>
20a. ACCIDENT <input checked="" 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.) <b>Plane Crash</b>		
20c. TIME OF INJURY Hour <b>6:25 A.M.</b> Month, Day, Year <b>5/17/59</b>			20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Farm</b>		
20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20f. CITY, TOWN, OR LOCATION <b>R. F. D. Atlanta</b>		COUNTY <b>Macon</b>	STATE <b>Missouri</b>
21. I attended the deceased from <b>6:25</b> to <b>A.</b> and last saw <sup>her</sup> <sub>him</sub> alive on <b>6:25</b> A. m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (In full name) <b>Lester Hutton Cosover</b>			22b. ADDRESS <b>Macon, Missouri</b>	22c. DATE SIGNED <b>5/20/59</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>May 19, 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Moriah Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Kansas City, Missouri</b>		
24. FUNERAL DIRECTOR <b>Lester Hutton</b>			25. DATE RECD. BY LOCAL REG. <b>5/20/59</b>	REGISTRAR'S SIGNATURE <b>Ruth McNeely</b>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

Date Filed ..... 5-27-50

MS SEP 29 1950

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 *Charles L. Heitton*

Licensed Embalmer No. *4577*  
P. O. Address *Murrow, 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.