

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-020362

FILED JUL 7 1959 Registration District No. 27 Primary Registration District No. 3005 STATE FILE NUMBER Registrar's No. 77

1. PLACE OF DEATH a. COUNTY <b>BATES</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>CAS</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>BUTLER</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>HARRISONVILLE</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
e. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Burke Memorial Hospital</b>		Length of stay in lb <b>2 wks</b>	d. STREET ADDRESS (If outside, give location) <b>RFD 3</b>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>EDWARD</b> Middle <b>George</b> Last <b>THEENER</b>			4. DATE OF DEATH Month <b>June</b> Day <b>25</b> Year <b>1959</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>FEB. 5, 1876</b>	9. AGE (In years last birthday) <b>83</b>	FUNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMER</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>BREESE, ILLINOIS</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13a. FATHER'S NAME <b>Ferdinand Theener</b>		13b. MOTHER'S MAIDEN NAME <b>Katherine Dittmar</b>		14. NAME OF HUSBAND OR WIFE <b>LYDIA GRAPER</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>now</b>	17. INFORMANT Address <b>William Theener Harrisonville, 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>Congestive Heart Failure</b>					INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (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>4341</b>					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 _____ a.m. _____ p.m. Month, Day, Year _____					
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 <b>June 14</b> to <b>June 25</b> and last saw him alive on <b>June 25, 1959</b> Death occurred at <b>11:30 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>Paul H. Green D.O.</b>			22b. ADDRESS <b>HARRISONVILLE, Mo.</b>		22c. DATE SIGNED <b>6-27-59</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>June 25, 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Pleasant Ridge Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>HARRISONVILLE, Mo.</b>
24. FUNERAL DIRECTOR <b>Atkinson Dickey Harrisonville, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>June 27-59</b>		26. REGISTRAR'S SIGNATURE <b>Ronald W. Gray</b>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

securing the medical certification in the specific manner required by 193.140 MoRS 1949. 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.

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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 *Robert W. Wilkinson* .....

Licensed Embalmer No. *4902* .....

P. O. Address *Harrisonville, 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.