

R DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED JUL 13 1959

59-022409

Registration District No. 276 Primary Registration District No. 4410 Registrar's No. 2.1 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>Phelps</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Phelps</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. James</b>	Length of stay in 1b <b>4 months</b>	c. CITY OR TOWN <b>St. James</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>Stricker Clinic</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>218 Cartall</b>
Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>			

3. NAME OF DECEASED (Type or print) First <b>Dayna</b> Middle <b>Joan</b> Last <b>Ebbesmeyer</b>			4. DATE OF DEATH Month <b>July</b> Day <b>9</b> Year <b>1959</b>	
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5. SEX <b>F</b>	6. COLOR OR RACE <b>white</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>3/1/59</b>	9. AGE (last birthday) IF UNDER 1 YEAR Months <b>4</b> Days <b>1</b> Hours <b>0</b> Min. <b>0</b>	IF UNDER 24 HR Hours <b>0</b> Min. <b>0</b>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>	11. BIRTHPLACE (City and state or country) <b>Rolla, Mo.</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
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13a. FATHER'S NAME <b>Arthur Ebbesmeyer</b>	13b. MOTHER'S MAIDEN NAME <b>Joan Sebacher</b>	14. NAME OF HUSBAND OR WIFE <b>none</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, <b>no</b> or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. <b>none</b>	17. INFORMANT Address <b>Arthur Ebbesmeyer, St. James</b>
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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>Acute Heart Failure</b>		INTERVAL BETWEEN ONSET AND DEATH <b>30 Min</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Congenital Atrioventricular Septal Defect</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>Acute Diffuse Upper Respiratory Infection</b>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
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19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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.)
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20c. TIME OF INJURY. Hour <b>12:30</b> a.m. <b>PM</b> 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
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21. I attended the deceased from <b>May 1969</b> to <b>July 1957</b> and last saw her alive on <b>July 5, 1957</b> Death occurred at <b>12:30 P.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE (Degree or title) <b>Samuel C. Bonney M.D.</b>	22b. ADDRESS <b>Stricker Clinic St James Mo</b>	22c. DATE SIGNED <b>7/10/59</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>7/9/59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. Charles Borromeo</b>	23d. LOCATION (City, town, or county) (State) <b>St. Charles Mo.</b>
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24. FUNERAL DIRECTOR <b>James G. ...</b>	25. DATE RECD. BY LOCAL REG. <b>7-8-59</b>	26. REGISTRAR'S SIGNATURE <b>Ruth B. Powell</b> <i>by E. D. ...</i>
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(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by  
or by \_\_\_\_\_; Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Jesse Gahr

Licensed Embalmer No. 4486

P. O. Address St. James

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.