

# MARI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS AUG 28 1959

59-028014

INDEXED

Registration District No. 002 Primary Registration District No. 5010 Registrar's No. 5012

STATE FILE NUMBER  
111

<b>1. PLACE OF DEATH</b> a. COUNTY <b>ANDREW</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> COUNTY <b>ANDREW</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>EMPIRE TOWNSHIP</b>		c. CITY OR TOWN <b>UNION STAR</b>	
Length of stay in 1b		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>1 mi. west Union Star</b>		d. STREET ADDRESS (If outside, give location) <b>1 mi. west Union Star</b>	
Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	

<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <b>SARAH CRITTENDEN MORAN</b>			<b>4. DATE OF DEATH</b> Month Day Year <b>August 14, 1959</b>		
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<b>5. SEX</b> <b>female</b>	<b>6. COLOR OR RACE</b> <b>white</b>	<b>7. Married</b> <input type="checkbox"/> <b>Never Married</b> <input type="checkbox"/> <b>Widowed</b> <input checked="" type="checkbox"/> <b>Divorced</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>11/20/74</b>	<b>9. AGE</b> (last birthday) <b>84</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
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<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>housewife</b>	<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>at home</b>	<b>11. BIRTHPLACE</b> (City and state or country) <b>Andrew County, Mo.</b>	<b>12. CITIZEN OF WHAT COUNTRY</b> <b>USA</b>
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<b>13a. FATHER'S NAME</b> <b>Jacob Eisiminger</b>	<b>13b. MOTHER'S MAIDEN NAME</b> <b>Mary Jane Baker</b>	<b>14. NAME OF HUSBAND OR WIFE</b> <b>Noah Moran</b>
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<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>	<b>16. SOCIAL SECURITY NO.</b> <b>none</b>	<b>17. INFORMANT</b> Address <b>Noah Moran, Jr., Union Star, Mo.</b>
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<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Occlusion</i> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <i>Generalized arteriosclerosis</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i> <i>10 yrs</i>
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)	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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<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/>	<b>SUICIDE</b> <input type="checkbox"/>	<b>HOMICIDE</b> <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)
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<b>20c. TIME OF INJURY</b> Hour a.m. p.m.	<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>
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<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)	<b>20f. CITY, TOWN, OR LOCATION</b>	<b>COUNTY</b>	<b>STATE</b>
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21. I attended the deceased from Dec. 1956 to Aug 14 1959 and last saw her alive on Aug 14 1959  
 Death occurred at 7:00 PM on the date stated above, and to the best of my knowledge, from the causes stated.

<b>22a. SIGNATURE</b> (Degree or title) <i>Harold Fowler M.D.</i>	<b>22b. ADDRESS</b> <i>Wayville, Mo</i>	<b>22c. DATE SIGNED</b> <i>8/15/59</i>
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<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>burial</b>	<b>23b. DATE</b> <b>Aug. 16, 1959</b>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Fillmore Cemetery</b>	<b>23d. LOCATION</b> (City, town, or county) (State) <b>Fillmore, Missouri</b>
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<b>24. FUNERAL DIRECTOR</b> Address <i>Breit Funeral Home Savannah</i>	<b>25. DATE RECD. BY LOCAL REG.</b> <i>8-21</i>	<b>26. REGISTRAR'S SIGNATURE</b> <i>Fullivan Sparks</i>
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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 James B. Hawkins

Licensed Embalmer No. 4536

P. O. Address Severson

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.