

DEPT. OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-036822

FILED VS NOV 9 1959 184 Primary Registration District No. 3038 Registrar's No. 119 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Lincoln</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Lincoln</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Brookfield</u>		Length of stay in 1b <u>1 hour</u>		c. CITY OR TOWN <u>Brookfield</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>In Taxi on street</u>				d. STREET ADDRESS (If outside, give location) <u>207 S. Caldwell</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <u>Bernice Pearl Sterling</u>				4. DATE OF DEATH Month Day Year <u>November 2, 1959</u>				
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>9/13/1898</u>		
9. AGE (last birthday) <u>61</u>		IF UNDER 1 YEAR Months <u>1</u> Days <u>19</u> Hours <u></u> Min. <u></u>		IF UNDER 24 HR Hours <u></u> Min. <u></u>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>in home</u>		11. BIRTHPLACE (City and state or country) <u>Milan, Missouri</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>	
13a. FATHER'S NAME <u>Robert L. Sterling</u>			13b. MOTHER'S MAIDEN NAME <u>Norma Fanning</u>			14. NAME OF HUSBAND OR WIFE <u>none</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>			16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>Louis J. Anesi, Kirksville, Mo.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Probable Cerebral Vascular accident</u>							INTERVAL BETWEEN ONSET AND DEATH <u>10 minutes</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) <u>Malignant Hypertension</u>					4-5 months	
DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Adenoidal mass RUC</u>						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		
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 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		
21. I attended the deceased from <u>1958</u> to <u>1959</u> and last saw ^{her} him alive on <u>10-30-59</u> Death occurred at <u>11 A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <u>B D Howell MD</u>				22b. ADDRESS <u>Brookfield Mo</u>		22c. DATE SIGNED <u>11-3-59</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>Nov. 4, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Shatto Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Milan, Missouri</u>			
24. FUNERAL DIRECTOR <u>Hill Funeral Home, Brookfield, Mo.</u>				25. DATE RECD. BY LOCAL REG. <u>11-4-59</u>		26. REGISTRAR'S SIGNATURE <u>Katharine Johnson</u>		

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 me
or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed

Seward I. Wad

Licensed Embalmer No.

4172

P. O. Address

Brown

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.