

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH
FILED VS FEB 1 1960

-60-001243

Registration District No. 133 Primary Registration District No. _____ Registrar's No. 13 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Harrison</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Harrison</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Rural Sherman Twp.</u>		Length of stay in 1b <u>50 yr</u>	c. CITY OR TOWN <u>Rural Sherman Twp.</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>At home</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>8 mile SE Bethany</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Bessie</u> Middle <u>Maude</u> Last <u>Sanders</u>	4. DATE OF DEATH Month <u>1</u> Day <u>25</u> Year <u>1960</u>
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>10-31-79</u>	9. AGE (last birthday) <u>80</u>	IF UNDER 1 YEAR Months <u>2</u> Days <u>24</u> Hours <u></u> Min. <u></u>	IF UNDER 24 HR Hours <u></u> Min. <u></u>
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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>Farm</u>	11. BIRTHPLACE (City and state or country) <u>Harrison County, Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>U. S.</u>
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13a. FATHER'S NAME <u>Phillip Nighthart</u>	13b. MOTHER'S MAIDEN NAME <u>Elizabeth Smith</u>	14. NAME OF HUSBAND OR WIFE <u>Oscar</u>
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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>do not know</u>	17. INFORMANT <u>Garland Sanders, Bethany, Mo.</u>	Address
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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:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Massive Cerebral Hemorrhage</u>		<u>1 hour</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Hypertensive Cardio-Vascular Disease</u>	<u>10 years</u>
	DUE TO (c)	

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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
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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.) <u>---</u>
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m. _____	Month, Day, Year <u>-----</u>
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20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>---</u>	20f. CITY, TOWN, OR LOCATION <u>---</u>	COUNTY	STATE
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21. I attended the deceased from 2/17/58 to 1/25/60 and last saw ^{her}him alive on 1/14/60
 Death occurred at 8:10 AM on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Wm McCarty</u>	(Degree or title) <u>D. O.</u>	22b. ADDRESS <u>Bethany, Mo.</u>	22c. DATE SIGNED <u>1-26-60</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>1-28-1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Antioch</u>	23d. LOCATION (City, town, or county) (State) <u>Bethany, Mo.</u>
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24. FUNERAL DIRECTOR <u>W. H. Jones</u>	ADDRESS <u>Bethany, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>1-26-1960</u>	26. REGISTRAR'S SIGNATURE <u>Gella Mayley</u>
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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 M. B. Haas
M. B. Haas

Licensed Embalmer No. 3899

P. O. Address Bethany, 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.