

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-032403

STATE FILE NUMBER

Registration District No. 116 Primary Registration District No. 3020 Registrar's No. 225

FILED OCT 2 1961

DATE AMENDED

1. PLACE OF DEATH a. COUNTY FRANKLIN		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO. b. COUNTY FRANKLIN	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN WASHINGTON		c. CITY OR TOWN GRAY SUMMIT	
Length of stay in 1b:		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. FRANCIS HOSPITAL		d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last SARAH HELEN HANEY			4. DATE OF DEATH Month Day Year SEPT. 27 1961		
--	--	--	--	--	--

5. SEX FEMALE	6. COLOR OR RACE WHITE	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH JULY 28, 1896	9. AGE (last birthday) 65	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
-------------------------	----------------------------------	---	--	-------------------------------------	--------------------------------	------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE	10b. KIND OF BUSINESS OR INDUSTRY HOUSEWORK	11. BIRTHPLACE (City and state or country) ALTON, ILL.	12. CITIZEN OF WHAT COUNTRY U.S.A.
---	---	--	--

13a. FATHER'S NAME HAWES SUTTON	13b. MOTHER'S MAIDEN NAME NELLIE LOWE	14. NAME OF HUSBAND OR WIFE JAY HANEY
---	---	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO	16. SOCIAL SECURITY NO. NONE	17. INFORMANT MR. JAY HANEY Address GRAY SUMMIT, MO.
---	--	---

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage		INTERVAL BETWEEN ONSET AND DEATH 12 hours
DUE TO (b) Arterio-Sclerosis		
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 type="checkbox"/> No <input type="checkbox"/> Unknown
---	--

19. WAS AUTOPSY PERFORMED? YES <input 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.)
--	---	--

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 Sept 27, 1961 to Sept 27, 1961 and last saw her alive on Sept 27, 1961
Death occurred at 6:00 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>L. J. Munch</i>	(Degree or title) M.D.	22b. ADDRESS <i>208 E. Washington Ave.</i>	22c. DATE SIGNED 9/29/61
--------------------------------------	----------------------------------	---	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE OCT. 4, 1961	23c. NAME OF CEMETERY OR CREMATORY UNION CEMETERY	23d. LOCATION (City, town, or county) UNION MO.
--	----------------------------------	---	---

24. FUNERAL DIRECTOR OLTMANN FUNERAL HOME	ADDRESS UNION, MO.	25. DATE RECD. BY LOCAL REG. 9/29/61	26. REGISTRAR'S SIGNATURE <i>L. J. Munch</i>
---	------------------------------	--	---

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

ITEM NO. SHOULD READ

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 Ralph Ottmann

Licensed Embalmer No. 4808

P. O. Address Union, 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.