

FILED AUG 15 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **21934**
Registrar's No. **45**

BIRTH NO. _____ REG. DIST. NO. **137** PRIMARY REG. DIST. NO. **5508**

1. PLACE OF DEATH a. COUNTY Henry		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo b. COUNTY Henry	
b. CITY OR TOWN Rural, Deswater Twp. (If outside corporate limits, write R.P.M. and give length of stay in this place)		c. CITY OR TOWN Rural, Deswater Twp. (If rural, give location)	
d. FULL NAME OF HOSPITAL OR INSTITUTION 4 mi West Montrose mo		e. STREET ADDRESS 4 mi West Montrose mo	
3. NAME OF DECEASED (Type or Print) a. (First) Regina b. (Middle) Justin c. (Last) Lesmeister		4. DATE OF DEATH (Month) (Day) (Year) Aug 8-1955	
5. SEX F	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH 30 June 1890
9. AGE (In years last birthday) 65		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife	11. BIRTHPLACE (City and State or Foreign Country) Mo
12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME Peter Gerard	
13b. MOTHER'S M maiden name Justina Digerich		14. NAME OF HUSBAND OR WIFE Louie Lesmeister	
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'S SIGNATURE OR NAME Louie Lesmeister		ADDRESS Montrose	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) Cerebral Vascular Accident			
MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Vascular Accident			
INTERVAL BETWEEN ONSET AND DEATH CHRONIC			
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.			
II. OTHER SIGNIFICANT CONDITIONS Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ 331X			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Nov , 19 54 , to Aug. 1 , 19 55 , that I last saw the deceased alive on Aug. 1 , 19 55 , and that death occurred at _____ m., from the causes and on the date stated above.			
23a. SIGNATURE R. H. Brownsberger M.D. (Degree or title)		23b. ADDRESS Appleton City, Mo.	23c. DATE SIGNED Aug. 10, 1955
24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE 8-11-55	24c. NAME OF CEMETERY OR CREMATORY Montrose Catholic	24d. LOCATION (City, town, or county) (State) Montrose Mo
DATE REC'D BY LOCAL REG. 8-11-55	REGISTRAR'S SIGNATURE Florence Adair	42-0	25. FUNERAL DIRECTOR'S SIGNATURE Sickman-Dunning ADDRESS Clinton Mo

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

5490

1955

SEP 8

JAN 13 1958

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 *Robert L. Dunne*

Licensed Embalmer No. *47*

P. O. Address *Clinton*

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.