

FILED APR 17 1940

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 10191

Registration District No. 1001

Primary Registration District No. 1001

Registrar's No. 265

1. PLACE OF DEATH:

(a) County Buchanan
(b) City or town St Joseph
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St Joseph's Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 weeks
In this community 3 weeks (Specify whether years, months or days)

3. (a) PRINT FULL NAME Mary Deeken 250

3. (b) If veteran, name war No 3. (c) Social Security No. None

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Mathew Deeken 6. (c) Age of husband or wife if alive 52 years

7. Birth date of deceased June 20 1896
(Month) (Day) (Year)

8. AGE: Years 43 Months 8 Days 15 If less than one day hr. min.

9. Birthplace Navasota Texas
(City, town, or county) (State or foreign country)

10. Usual occupation housewife

11. Industry or business --

12. Name Lawrence Gabriel

13. Birthplace unknown Germany
(City, town, or county) (State or foreign country)

14. Maiden name Mary Geisinger

15. Birthplace unknown Germany
(City, town, or county) (State or foreign country)

16. (a) Informant Matt Deeken

(b) Address Wathena, Kansas

17. (a) Wathena Kans (b) Date thereof March 6, 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Wathena, Kansas

18. (a) Signature of funeral director J. S. Sells

(b) Address Wathena, Kans

19. (a) march 6, 1940 Z. J. Nestlebusch
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Kansas (b) County Doniphan
(c) City or town Wathena
(If outside city or town limits, write "RURAL")
(d) Street No. --
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 5th
year 1940 hour 8 minute 45 P. M.

21. I hereby certify that I attended the deceased from Feb. 12 1940 to March 5 1940
that I last saw h. alive on March 5 1940
and that death occurred on the date and hour stated above.

Immediate cause of death BRAIN TUMOR 9 mo.
Duration

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings: BRAIN TUMOR
Of operations Operated Dr. Teichner - KC, Kan
Of autopsy University Hospital
no autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) no

(b) Date of occurrence _____

(c) Where did injury occur? none
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? no

While at work? no (Specify type of place) (e) Means of injury _____

23. Signature P. E. Thompson (M. D. no)
Address St. Charles, Mo. Date signed 4/6/40

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

11
23

557A

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 _____, Registered Apprentice No. _____, working under my personal supervision.

Signed Alfred L. Dadds
Licensed Embalmer No. No 3023
P. O. Address Wathuna Kans

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 this body is not embalmed, above space should be left blank.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 10 191

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 85

Primary Registration District No. 1001

Registrar's No. 265

1. PLACE OF DEATH:

(a) County Buchanan
(b) City or town St Joseph
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution.
In this community: (Specify whether years, months or days)

3. (a) PRINT FULL NAME

Mary Deeken

3. (b) If veteran, name war. 3. (c) Social Security No.

4. Sex m 5. Color w 6. (a) Single, widowed, married, divorced m
6. (b) Name of husband or wife. 6. (c) Age of husband, or wife, if alive year

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years 43 Months 8 Days 15 If less than one day hr. min.

9. Birthplace (City, town, or county) (State or foreign country)

10. Usual occupation

11. Industry or business

12. Name

13. Birthplace (City, town, or county) (State or foreign country)

14. Maiden name (City, town, or county) (State or foreign country)

15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant

(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) 5-29-40 (b) N. J. Neethling (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County
(c) City or town (If outside city or town limits write "RURAL")
(d) Street No. (If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

19. MEDICAL CERTIFICATION

20. DATE OF DEATH Month Mar day 5 year 1940 hour minute M.

21. I hereby certify that I attended the deceased from 19 to 19 that I last saw him alive on and that death occurred on the date and hour stated above.

Immediate cause of death Brain Tumor

Due to yes - malignant

Other conditions (include pregnancy within 3 months of death) 53'

Major findings:

Of operations

Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of place) (c) Means of injury

23. Signature J. Thompson M. D. or other. Address St Joseph Date signed

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

SUPPLEMENTAL COPY

S-10191 1940