

FILED JAN 16 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 288

BIRTH NO. _____ REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 1000 Registrar's No. 8

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Buchanan	
b. CITY (If outside corporate limits, write RURAL and give OR TOWN St. Joseph		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Joseph	
d. FULL NAME OF HOSPITAL OR INSTITUTION Ambulance in route to St. Joseph's Hospital 3		d. STREET ADDRESS (If rural, give location) 226 1/2 Ohio St.	

3. NAME OF DECEASED (Type or Print)	a. (First) Ethel	b. (Middle) Mary	c. (Last) McFadden	4. DATE OF DEATH (Month) (Day) (Year)
				1 3 1949

5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED Married	8. DATE OF BIRTH March 21, 1897	9. AGE (In years last birthday) 51	IF UNDER 1 YEAR Months 9	IF UNDER 24 HRS. Hours Min. 13
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife	10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (State or foreign country) St. Joseph, Missouri	12. CITIZEN OF WHAT COUNTRY U.S.A.
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13a. FATHER'S NAME William Gleason	13b. MOTHER'S MAIDEN NAME Sarah Jane Gallup	14. NAME OF HUSBAND OR WIFE John McFadden
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY (If yes, give war or dates of service) 499-20-3278	17. INFORMANT'S SIGNATURE OR NAME ADDRESS John McFadden, 226 1/2 Ohio St., City
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 3 or 4 hrs.
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hemorrhage stomach		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Ulcer of stomach DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		5400	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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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
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22. I hereby certify that I attended the deceased from 12/31, 1948, to 12/31, 1948, that I last saw the deceased alive on 12/31, 1948, and that death occurred at 8:00 m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Frank H. Hagan	23b. ADDRESS M.D. 670 Jones St.	23c. DATE SIGNED 1/5/49
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 1-5-49	24c. NAME OF CEMETERY OR CREMATORY Mt. Auburn	24d. LOCATION (City, town, or county) (State) St. Joseph, Mo
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DATE REC'D BY LOCAL REG. 1-7-49	REGISTRAR'S SIGNATURE E. G. Jenkins	382	FUNERAL DIRECTOR'S SIGNATURE J. C. Rupp	6054 Pfor Ave. St. Joseph, Mo.
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(Licensed Embalmer's Statement on Reverse Side)

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

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. 213

working under my personal supervision.

Signed Mandal B. State
Student Embalmer

Signed John E. Rupp
Licensed Embalmer No. 3986

P. O. Address St. Joseph, 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 this body is not embalmed, fact should be so stated above.