

FILED JUN 20 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

18694

State File No. ....

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 1000 Registrar's No. 661

1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Buchanan</u>					
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Joseph</u>		c. LENGTH OF STAY (In this place) <u>30yr.</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Joseph</u>					
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>813 N. 22nd.</u>				d. STREET ADDRESS (If rural, give location) <u>813 N. 22nd.</u>					
3. NAME OF DECEASED (Type or Print) a. (First) <u>Lillian Ruth</u>			b. (Middle) <u>Robison</u>		c. (Last)		4. DATE OF DEATH (Month) (Day) (Year) <u>June 11 1949</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>		8. DATE OF BIRTH <u>Oct. 12, 1900</u>		9. AGE (In years last birthday) <u>48</u>	IF UNDER 1 YEAR Months <u>7</u> Days <u>29</u>	IF UNDER 2 WKS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sewing machine oper.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Miller Casket Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Helema Mo. U</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>			
13a. FATHER'S NAME <u>Otto Gnuschenke</u>			13b. MOTHER'S MAIDEN NAME <u>Anna Farrell</u>			14. NAME OF HUSBAND OR WIFE <u>Lenore Robison</u>			
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>495-26-1316</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Irene Gnuschenke</u>		ADDRESS <u>813 N. 22nd</u>			
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, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>CARCINOMA, BREAST</u>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>NONE</u> DUE TO (c) <u>NONE</u>  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>NONE</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 YRS</u>  <u>170X</u>		
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>NONE</u>						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>NO</u>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>NO</u>		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)					
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>June 11 49 3: A. M.</u>		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 <u>JUNE 5, 1949</u> , to <u>JUNE 11, 1949</u> , that I last saw the deceased alive on <u>June 11, 1949</u> and that death occurred at <u>3:00 A.M.</u> , from the causes and on the date stated above.									
23a. SIGNATURE <u>Allen S. Herman M.D.</u>				23b. ADDRESS <u>St. Joseph, Missouri</u>		23c. DATE SIGNED <u>6-11-49</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>June 13 1949</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Helena Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Helena Mo.</u>			
DATE REC'D BY LOCAL REG. <u>June 16, 1949</u>		REGISTRAR'S SIGNATURE <u>to to Jenkins</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Helena Bowman Funeral</u>		ADDRESS <u>319 d. 15th St. Joseph Mo.</u>			

(Licensed Embalmer's Statement on Reverse Side)

Done

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

*Dr. William Alderman*

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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 .....  
Student Embalmer

Signed *William Alderman*

Licensed Embalmer No. *4535*

P. O. Address *219 S. 10<sup>th</sup> St. Fargo, N.D.*

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.