

FILED JUL 25 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 22639

BIRTH NO. _____ REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 1000 Registrar's No. 792

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 township) OR TOWN St. Joseph		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Joseph	
c. LENGTH OF STAY (in this place) 32 yrs.			
d. FULL NAME OF HOSPITAL OR INSTITUTION 1825 So. 9th St. (Home)		d. STREET ADDRESS (If rural, give location) 1825 So. 9th st.	

3. NAME OF DECEASED (Type or Print)	a. (First) MARY	b. (Middle) LOU	c. (Last) SAUNDERS	4. DATE OF DEATH (Month) (Day) (Year) 7 16 1949
-------------------------------------	------------------------	------------------------	---------------------------	--

5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH 7-11-1869	9. AGE (In years last birthday) 80	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	IF UNDER 1 MIN. Hours	IF UNDER 1 MIN. Min.
----------------------	-------------------------------	---	-----------------------------------	---	------------------------	-----------------------	-----------------------	----------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper	10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (State or foreign country) Jefferson Co., Kansas	12. CITIZEN OF WHAT COUNTRY U.S.A.
--	---	--	---

13a. FATHER'S NAME John McKinney	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Harvey W. Saunders
---	--	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME Mary Leaverton, St. Joseph, Mo.	ADDRESS
---	-------------------------------------	--	---------

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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cardiac Failure (Acute)		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Coronary Artery Disease DUE TO (c) Asthma (prior)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Myocardial insufficiency		4/201	

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) (Min.)	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 10-18 1948, to 7-16 1949, that I last saw the deceased alive on 7-1 1949, and that death occurred at 5:00 A.M., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) R. W. Kiebe, M.D., D.	23b. ADDRESS 703 Bldg St Joseph Mo.	23c. DATE SIGNED 7/16/49
---	--	---------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 7-18-1949	24c. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cemetery	24d. LOCATION (City, town, or county) (State) St. Joseph, Missouri
---	----------------------------	---	---

DATE REC'D BY LOCAL REG. July 18, 1949	REGISTRAR'S SIGNATURE E. G. Jenkins	382	25. FUNERAL DIRECTOR'S SIGNATURE John E. [unclear]	ADDRESS St. Joseph, Mo.
---	--	-----	---	--------------------------------

(Licensed Embalmer's Statement on Reverse Side)

COPY THIS FORM 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. _____

working under my personal supervision.

Student
Student Embalmer

Signed _____

John E. Rupp

Licensed Embalmer No. *2986*

P. O. Address *St. Joseph,*

Note: The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his **OWN HANDWRITING**. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.