

FILED OCT 24 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **33120**

BIRTH NO. _____ REG. DIST. NO. **42** PRIMARY REG. DIST. NO. **1000** Registrar's No. **1129**

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Joseph 2		c. LENGTH OF STAY (in this place) 20 yrs.	
d. FULL NAME OF HOSPITAL OR INSTITUTION State Hospital # 2		d. STREET ADDRESS (If rural, give location) Unknown	

3. NAME OF DECEASED (Type or Print) / a. (First) Minnie	b. (Middle) Frances	c. (Last) Wholey	4. DATE OF DEATH (Month) (Day) (Year) 10 16 1949
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, (Specify) Divorced 3	8. DATE OF BIRTH 2-22-1888	9. AGE (In years last birthday) 61	IF UNDER 1 YEAR Months	IF UNDER 4 HRS. Days	IF UNDER 15 MIN. Hours	IF UNDER 15 MIN. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	10b. KIND OF BUSINESS OR INDUSTRY Invalidided	11. BIRTHPLACE (State or foreign country) Peabody, Kansas /	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Thomas Kerns	13b. MOTHER'S MAIDEN NAME Elizabeth Kunkleman	14. NAME OF HUSBAND OR WIFE None
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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 Mildred Kitchen, Kansas City, Kansas	ADDRESS Kansas City, Kansas
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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, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 20 hrs
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Syphilitic Myocarditis		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. arteriosclerosis		3 hrs +	

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 checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **Nov 15, 1948**, to **10-16, 1949**, that I last saw the deceased alive on **10-17, 1949**, and that death occurred at **2:45 a. m.**, from the causes and on the date stated above.

23a. SIGNATURE S. Cousins M.D. (Degree or title)	23b. ADDRESS State Hospital # 2	23c. DATE SIGNED 10-18-1949
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 10-17-1949	24c. NAME OF CEMETERY OR CREMATORY Kansas City	24d. LOCATION (City, town, or county) (State) Kansas
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DATE REC'D BY LOCAL REG Oct. 18, 1949	REGISTRAR'S SIGNATURE G. B. Jenkins	382	25. FUNERAL DIRECTOR'S SIGNATURE Johna Reed, St. Joseph, Mo.	ADDRESS
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(Licensed Embalmer, Statement on Reverse Side)

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

No. 300
10-48
11
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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 _____

Body was not embalmed

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed _____

John E. Kupp

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.