

FILED APR 24 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 12032

BIRTH NO. REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 1000 Registrar's No. 475

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) 43 Years		d. STREET ADDRESS (If rural, give location) 1020 Powell Street	
d. FULL NAME OF HOSPITAL OR INSTITUTION 1020 Powell St.			
3. NAME OF DECEASED (Type or Print) a. (First) Catherine b. (Middle) Gadol c. (Last) Moine			4. DATE OF DEATH (Month) (Day) (Year) April 17 1950
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH July 5, 1862
9. AGE (In years last birthday) 87		10. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Troy, Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Peter Gadol		13b. MOTHER'S MAIDEN NAME Josephine Kibler	
14. NAME OF HUSBAND OR WIFE Louis			
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 Mrs O.H. Halstead		ADDRESS 1020 Powell St.	
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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerosis Heart disease 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.	
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) (Minute)		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 July, 1949, to 17 April, 1950, that I last saw the deceased alive on 17 April, 1950, and that death occurred at 5:30 P. M., from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) Clement A. Jenkins		23b. ADDRESS St. Joseph Mo	
23c. DATE SIGNED 4-18-50			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 4/19/1950	
24c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		24d. LOCATION (City, town, or county) (State) St. Joseph, Missouri	
DATE REC'D BY LOCAL REG. April 20, 1950		REGISTRAR'S SIGNATURE G. C. Jenkins 382	
25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Herman W. Sidenfaden 1802 Union St.			

(Licensed Embalmer's Statement on Reverse Side)

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

0117

0117

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 Elmer Thomas

Licensed Embalmer No. 2640

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.