

FILED APR 29 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **13624**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **174** PRIMARY REG. DIST. NO. **3035** Registrar's No. **34**

542

1. PLACE OF DEATH a. COUNTY <b>Lafayette</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>Lafayette</b>	
b. CITY (If outside corporate limits, write RURAL and give OR TOWN <b>Lexington</b> )		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Wellington</b>	
c. LENGTH OF STAY (In this place) <b>4 da.</b>		d. STREET ADDRESS (If rural, give location) <b>R.F.D. 1</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Memorial Hospital</b>			

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH		
a. (First) <b>ANNA</b>	b. (Middle) <b>E.</b>	c. (Last) <b>SOENDKER</b>	(Month) <b>April</b>	(Day) <b>17</b>	(Year) <b>1950</b>

5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>Dec. 2, 1866</b>	9. AGE (In years last birthday) <b>83</b>	IF UNDER 1 YEAR Months <b>4</b> Days <b>15</b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	11. BIRTHPLACE (State or foreign country) <b>Holstene, Mo.</b>	12. CITIZEN OF WHAT COUNTRY? <b>Yes U.S.A.</b>
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13a. FATHER'S NAME <b>Henry Soendker</b>	13b. MOTHER'S MAIDEN NAME <b>Schnieker</b>	14. NAME OF HUSBAND OR WIFE <b>Henry Soendker</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>No</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Viola Soendker</b>	ADDRESS <b>5026 E. 7th. K.C. MO.</b>
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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  <b>260XF</b>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Chronic myocarditis</b>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Hypertension &amp; nephritis and diabetes.</b> DUE TO (c) <b>Fracture of right hip (antechantaleric)</b>		
II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION <b>None</b>	19b. MAJOR FINDINGS OF OPERATION <b>None</b>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) <b>Yes accident</b>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Home</b>	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <b>Wellington Laf. Mo.</b>
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <b>April 6, 1950 12:00 noon</b>	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? <b>Fell on floor</b>
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22. I hereby certify that I attended the deceased from **Apr. 6, 1950**, to **April 17, 1950** that I last saw the deceased alive on **April 16, 1950** and that death occurred at **7:40A** m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <b>Ben H. Brasler M.D.</b>	23b. ADDRESS <b>Lexington, Mo.</b>	23c. DATE SIGNED <b>4/18/50</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>April 19, 1950</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Evangelical Cem.</b>	24d. LOCATION (City, town, or county) (State) <b>Wellington, Mo.</b>
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DATE REC'D BY LOCAL REG. <b>April 24-1950</b>	REGISTRAR'S SIGNATURE <b>Minerva Eastbrook</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>J. Clair Sheppard</b>	ADDRESS <b>Wellington, Mo.</b>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED APR 21 1950  
District Health Office No. 8

District File Number \_\_\_\_\_  
Date Filed 4-28-50

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 *J. Clair Sheppard*

Licensed Embalmer No. 4179

P. O. Address *Wellington, Md.*

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.