

FILED JUN 12 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 15990

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 4052 Registrar's No. 662

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 town or township) <u>Agency</u>		c. LENGTH OF STAY (in this place) <u>68 yrs.</u>	
c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Agency</u>		d. STREET ADDRESS (If rural, give location) <u>0110</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>---</u>		d. STREET ADDRESS (If rural, give location) <u>0</u>	
3. NAME OF DECEASED (Type or Print) a. (First) <u>Mary</u> b. (Middle) <u>Almedia</u> c. (Last) <u>Degen</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>June 2, 1950</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>May 17, 1881</u>
9. AGE (In years last birthday) <u>69</u>		IF UNDER 1 YEAR Months <u>0</u> Days <u>15</u>	IF UNDER 24 HRS. Hours <u>---</u> Min. <u>---</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	11. BIRTHPLACE (State or foreign country) <u>Creston, Iowa</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13a. FATHER'S NAME <u>Wright B. Stacey</u>	
13b. MOTHER'S MAIDEN NAME <u>Katherine M. Manley</u>		14. NAME OF HUSBAND OR WIFE <u>Louis J. Degen</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Louis P. Kerber</u>		ADDRESS <u>Agency, Mo.</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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Diabetes Mellitus</u>  Other ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Myocardial insufficiency</u> <u>Cardiac decompensation</u> DUE TO (c) <u>Hypertension + Obesity</u>  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Cerebral hemorrhage + hemiplegia</u>	
19a. DATE OF OPERATION <u>---</u>		19b. MAJOR FINDINGS OF OPERATION <u>---</u>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>---</u>	
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>---</u>		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) <u>Agency, Mo.</u> (STATE) <u>Mo.</u>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) <u>---</u>		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? <u>---</u>			
22. I hereby certify that I attended the deceased from <u>Sept</u> , 19 <u>48</u> , to <u>June 2</u> , 19 <u>50</u> , that I last saw the deceased alive on <u>May 31</u> , 19 <u>50</u> , and that death occurred at <u>7:35 A.M.</u> , from the causes and on the date stated above.			
23a. SIGNATURE <u>W. Grant M.D.</u> (Degree or title)		23b. ADDRESS <u>St. Joseph Mo.</u>	
23c. DATE SIGNED <u>6.3.50</u>		24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	
24b. DATE <u>6/5/50</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Mt. Auburn</u>	
24d. LOCATION (City, town, or county) (State) <u>St. Joseph, Mo.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Walter Bowman</u> ADDRESS <u>St. Joseph, Mo.</u>	
DATE REC'D BY LOCAL REG. <u>June 7, 1950</u>		REGISTRAR'S SIGNATURE <u>L. S. Jenkins</u> 382	

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

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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 James B. Hawkins

Licensed Embalmer No. 4536

P. O. Address 319 S. 10<sup>th</sup> St. Grand No.

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.