

FILED OCT 16 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **29452**
Registrar's No. **1141**

BIRTH NO. _____ REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 1000

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 township) <u>St. Joseph</u>	c. LENGTH OF STAY (in this place) <u>824 Bx 124</u>	c. CITY (If outside corporate limits, write RURAL and give township) <u>St. Joseph</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>State Hospital No. 2.</u>		d. STREET ADDRESS (If rural, give location) <u>610 E. Kansas Ave.</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>HAZEL</u> b. (Middle) <u>-</u> c. (Last) <u>DORRICK</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>10-9-1950</u>
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Single</u>	8. DATE OF BIRTH <u>7-15-1890</u>	9. AGE (In years last birthday) Months Days Hours Mins. <u>60</u> <u>5</u> <u>2</u> <u>24</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.?</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	11. BIRTHPLACE (State or foreign country) <u>Unknown</u>		

13a. FATHER'S NAME <u>Unknown</u>	13b. MOTHER'S MAIDEN NAME <u>Unknown</u>	14. NAME OF HUSBAND OR WIFE <u>-</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Agnes Dorrick</u>	ADDRESS <u>610 E. Kansas Ave., St. Joseph, Mo.</u>
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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, ashenia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Hemorrhage of brain (Right side)</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Suddenly</u>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Syphilitic</u>		<u>4 yrs +</u>
	DUE TO (c) <u>psychotic</u>		<u>4 yrs</u>
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>

21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>No</u>	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)	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 8-10-, 1942, to 10-9-, 1950, that I last saw the deceased alive on 10-9-, 1950, and that death occurred at 10:15 a.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>P. E. Cassius M.D.</u>	23b. ADDRESS <u>State Hospital No. 2.</u>	23c. DATE SIGNED <u>10-9-1950</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>10-12-50</u>	24c. NAME OF CEMETERY OR CREMATORY <u>ASHLAND CEM.</u>	24d. LOCATION (City, town, or county) (State) <u>St. Joseph, Mo</u>
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DATE REC'D BY LOCAL REG. <u>Oct 12, 1950</u>	REGISTRAR'S SIGNATURE <u>Carl C. Carter</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>James A. Clark</u>	ADDRESS <u>120 Illinois St.</u>
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(Licensed Embalmer's Statement on Reverse Side)

0117
 2-1
 WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD
 By Maryway O. D.

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 _____

working under my personal supervision.

Student Embalmer No.

Signed.....

James Clark

Signed.....

Student Embalmer

Licensed Embalmer No. *4238*

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.