

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED NOV 4 1950

State File No. 33767  
4416

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY Jackson		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 Kansas City		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City	
d. FULL NAME OF HOSPITAL OR INSTITUTION General Hospital No. 1		d. STREET ADDRESS (If rural, give location) 708 Garfield	

3. NAME OF DECEASED (Type or Print) a. (First) Joseph	b. (Middle) E.	c. (Last) Wasserkrug	4. DATE OF DEATH (Month) (Day) (Year) 10 19 50
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5. SEX 0 MALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) SINGLE 0	8. DATE OF BIRTH DEZ-29-1889	9. AGE (In years last birthday) 60	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 1 YEAR Hours	IF UNDER 1 YEAR 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 NONE	11. BIRTHPLACE (State or foreign country) ST. JOSEPH, Mo.	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME HARRON WASSERKRUG	13b. MOTHER'S MAIDEN NAME AUGUSTA ANSSEN	14. NAME OF HUSBAND OR WIFE SINGLE
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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 Mrs. Rose Herberberg	ADDRESS St. Joseph, Mo.
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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
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary embolism		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Venous thrombophlebitis DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		401X	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from Oct. 18, 1950, to Oct. 19, 1950, that I last saw the deceased alive on Oct. 19, 1950, and that death occurred at 7:55A m., from the causes and on the date stated above.

23a. SIGNATURE B.I. Burns M.D. (Degree or title)	23b. ADDRESS 24th & Cherry	23c. DATE SIGNED 10-19-50
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24a. BURIAL, CREMATION, OR REMOVAL (Specify) Removal	24b. DATE 10-19-50	24c. NAME OF CEMETERY OR CREMATORY -	24d. LOCATION (City, town, or county) (State) St. Joseph Mo.
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DATE REC'D BY LOCAL REG. 10-19-50	REGISTRAR'S SIGNATURE Geraldine Holmes	25. FUNERAL DIRECTOR'S SIGNATURE B. W. Newcomer	ADDRESS S. Louis, Mo.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

*Dr. Daniel*

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.....  
Student Embalmer

Signed *Doyle R. Daniel*

Licensed Embalmer No. *4702*

P. O. Address *Leicester, Mass.*

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.

*not embalmed here*