

FILED NOV 20 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 36234

BIRTH NO. _____		REG. DIST. NO. <u>42</u>		PRIMARY REG. DIST. NO. <u>1000</u>		Registrar's No. <u>1284</u>	
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) OR TOWN <u>St. Joseph</u>		c. LENGTH OF STAY (in this place) <u>8 days</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Joseph</u> <u>0117</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Street Nursing Home</u> <u>1006 Dewey Avenue</u>				d. STREET ADDRESS (If rural, give location) <u>0</u> <u>3036 Lafayette</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Pearl</u>			b. (Middle) _____		c. (Last) <u>Mehrtens</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Nov. 13, 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>Jan. 19, 1878</u>	9. AGE (In years last birthday) <u>72</u>		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Practical Nurse</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self Employed</u>		11. BIRTHPLACE (State or foreign country) <u>Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>John W. Tucker</u>			13b. MOTHER'S MAIDEN NAME <u>Eugenia Ward</u>		14. NAME OF HUSBAND OR WIFE <u>Henry Mehrtens</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 ADDRESS <u>Mrs. Tena Cash 12 Brookside, St. Louis, Missouri.</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>Coronary of Heart</u>				INTERVAL BETWEEN ONSET AND DEATH <u>4 mo</u>	
		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.				<u>156A</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) _____		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) (Min.) _____		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 <u>16 Sept</u> , 19 <u>50</u> , to <u>13 Nov</u> , 19 <u>50</u> , that I last saw the deceased alive on <u>11 Nov</u> , 19 <u>50</u> , and that death occurred at <u>11:00a</u> m., from the causes and on the date stated above.							
23a. SIGNATURE <u>Chas W. Tracy</u> (Degree or title) <u>MD</u>				23b. ADDRESS <u>South Bldg. St. Joseph Mo</u>		23c. DATE SIGNED <u>13 Nov 50</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Nov. 15, 1950</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Mt. Auburn Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>St. Joseph Missouri</u>	
DATE REC'D BY LOCAL REG. <u>Nov 15, 1950</u>		REGISTRAR'S SIGNATURE <u>Carl C. Casper</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Heaton-Brownman Funeral Home, St. Joseph, Mo</u>			

(Licensed Embalmer's Statement on Reverse Side)

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

Dr. Owen W. D. Craig

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 *Eugene Wood*

Licensed Embalmer No. *3804*

P. O. Address *319 So 10th St Joseph,*

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.