

FILED NOV 25 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 36255

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 1000 Registrar's No. 1307

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Buchanan	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Joseph		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Joseph	
c. LENGTH OF STAY (in this place) 1 day		d. STREET ADDRESS (If rural, give location) 1008 Church	
d. FULL NAME OF HOSPITAL OR INSTITUTION Missouri Methodist Hospital			

3. NAME OF DECEASED (Type or Print) a. (First) Bertha b. (Middle) Vollmer c. (Last) Schroer			4. DATE OF DEATH (Month) (Day) (Year) Nov. 17, 1950		
5. SEX Female /	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed 2	8. DATE OF BIRTH Mar. 18, 1869	9. AGE (In years last birthday) 81	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) St. Louis, Missouri 0		12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME Gustav Vollmer		13b. MOTHER'S MAIDEN NAME Bertha Ruckiman		14. NAME OF HUSBAND OR WIFE George Schroer	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No None		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Prearranged Records	

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, asphyxia, 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) Central Accident		18 hrs	
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Left Hemiplegia DUE TO (c)		18 hrs	
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)	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 16 Nov, 1950, to 17 Nov, 1950, that I last saw the deceased alive on 17 Nov, 1950, and that death occurred at 8:00 a. m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Glen W. Craig M.D.		23b. ADDRESS 520 Francis St. Joseph, Mo.		23c. DATE SIGNED 17 Nov 50
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial 0	24b. DATE 11/20/50	24c. NAME OF CEMETERY OR CREMATORY Mount Auburn Cemetery	24d. LOCATION (City, town, or county) (State) St. Joseph, Missouri	
DATE REC'D BY LOCAL REG Nov. 22, 1950	REGISTRAR'S SIGNATURE Carl C. Casper	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Heaton Bowman Funeral Home St. Joseph, Mo.		

(Licensed Embalmer's Statement on Reverse Side)

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

Dr. Buren W. D. Craig

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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

*Sam P. Hankin*

Licensed Embalmer No. 4536

P. O. Address 319 S. 10<sup>th</sup> St. Jones

**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.