

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **19459**

RECORDED JUL 9 - 1951

BIRTH NO. _____ REG. DIST. NO. **42** PRIMARY REG. DIST. NO. **1000** Registrar's No. **699**

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Kansas		b. COUNTY Brown	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Joseph		c. LENGTH OF STAY (in this place) 2 weeks		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN White Cloud	
d. FULL NAME OF HOSPITAL OR INSTITUTION Leon Nursing Home		d. STREET ADDRESS (If rural, give location) 821 Prospect Ave.,		8150 8	
3. NAME OF DECEASED (Type or Print) a. (First) Lillie			b. (Middle) Belle		c. (Last) DeRoin
4. DATE OF DEATH (Month) (Day) (Year) June 29, 1951		5. SEX female		6. COLOR OR RACE white	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married		8. DATE OF BIRTH January 9, 1873		9. AGE (In years last birthday) 78	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Oscalosa, Iowa	
12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME Samuel McBee		13b. MOTHER'S MAIDEN NAME Freelove Kirtman	
14. NAME OF HUSBAND OR WIFE John DeRoin		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT'S SIGNATURE OR NAME Mr. John DeRoin, White Cloud, Kansas		18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) Cerebral hemorrhage		19. INTERVAL BETWEEN ONSET AND DEATH	
This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) Cerebral hemorrhage			
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hypertensive C.V. disease		DUE TO (c) disease			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 443x	
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 _____, 19____, to 6/29 1951 , that I last saw the deceased alive on 7/2 , 19____, and that death occurred at 1:10P m. , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) Scott C. Benson, M.D.		23b. ADDRESS 202 Phy Surg Bldg		23c. DATE SIGNED 7/2/51	
24a. BURIAL, CREMATION, REMOVAL (Specify) 5		24b. DATE 6/29/1951		24c. NAME OF CEMETERY OR CREMATORY. unk	
24d. LOCATION (City, town, or county) (State) White Cloud Kansas		DATE REC'D BY LOCAL REG. July 5, 1951		REGISTRAR'S SIGNATURE Carl C. Caslet	
25. FUNERAL DIRECTOR'S SIGNATURE Heaton-Brown Funeral Home - St Joseph, Mo.		ADDRESS			

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 Wool

Licensed Embalmer No. 3804

P. O. Address 319 50th St, A. J. Corp

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.