

FILED JUN 25 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **19495**

Registrar's No. **639**

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

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo 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	
d. FULL NAME OF HOSPITAL OR INSTITUTION MO. Methodist Hospital		d. STREET ADDRESS (If rural, give location) 611 1/2 North 3rd. Street	
3. NAME OF DECEASED (Type or Print) a. (First) Ella		b. (Middle) _____ c. (Last) Long	
4. DATE OF DEATH (Month) (Day) (Year) June 6 1951		5. SEX Fem. 3	
6. COLOR OR RACE Blk.		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed	
8. DATE OF BIRTH 12/25/1895		9. AGE (In years last birthday) 55	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY House work	
11. BIRTHPLACE (State or foreign country) Texas		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13a. FATHER'S NAME Unknown		13b. MOTHER'S MAIDEN NAME Unknown	
14. NAME OF HUSBAND OR WIFE Jess		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 Mrs Shirley Whitlow Milwaukee, Wis.	
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 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) _____ DUE TO (c) _____ 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 331X	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) (m.)		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>11/20/509</u> , to <u>6/6/51</u> , 19____, that I last saw the deceased alive on <u>6/5/51</u> , 19____, and that death occurred at <u>10:00Am.</u> , from the causes and on the date stated above.	
23a. SIGNATURE <i>Quinn W. Strain M.D.</i>		23b. ADDRESS Tootle Building St. Joseph, Mo.	
23c. DATE SIGNED 6/8/51		24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
24b. DATE 6/8/51		24c. NAME OF CEMETERY OR CREMATORY Ashland Cemetery	
24d. LOCATION (City, town, or county) (State) St. Joseph, Mo.		DATE REC'D BY LOCAL REG. June 18, 1951	
REGISTRAR'S SIGNATURE <i>Carl C. Casper</i>		5. FUNERAL DIRECTOR'S SIGNATURE <i>Stoney, Leonard Home</i>	
ADDRESS St. Joseph, Mo.			

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

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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 *John Roy Stamer*.....

Licensed Embalmer No. *2435*.....

P. O. Address *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.