

No. 300-10-48 APR 28 1952

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

5123 State File No. 12121

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 5132 Registrar's No. 430

|   |  |  |  |
|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY Buchanan   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE Missouri b. COUNTY Buchanan |  |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Rt #4, Agency Twp. |  | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Agency-Rural 0110                                 |  |
| c. LENGTH OF STAY (in this place) Life  |  | d. STREET ADDRESS (If rural, give location) RR #4 0  |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION Rt #4   |  |  |  |

|                                     |                 |             |                |  |
|-------------------------------------|-----------------|-------------|----------------|--|
| 3. NAME OF DECEASED (Type or Print) | a. (First) Lula | b. (Middle) | c. (Last) Pyne | 4. DATE OF DEATH (Month) (Day) (Year) April 15, 1952 |
|-------------------------------------|-----------------|-------------|----------------|--|

|               |                        |  |                           |                                    |                          |                          |                             |
|---------------|------------------------|--|---------------------------|------------------------------------|--------------------------|--------------------------|-----------------------------|
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow | 8. DATE OF BIRTH 12/28/68 | 9. AGE (In years last birthday) 83 | IF UNDER 1 YEAR Months 3 | IF UNDER 24 HRS. Days 18 | IF UNDER 24 HRS. Hours Min. |
|---------------|------------------------|--|---------------------------|------------------------------------|--------------------------|--------------------------|-----------------------------|

|  |  |   |                                 |
|--|--|---|---------------------------------|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House keeper | 10b. KIND OF BUSINESS OR INDUSTRY None | 11. BIRTHPLACE (State or foreign country) Sullivan Co, Mo 0 | 12. CITIZEN OF WHAT COUNTRY? A. |
|--|--|---|---------------------------------|

|                                   |   |                                      |
|-----------------------------------|---|--------------------------------------|
| 13a. FATHER'S NAME William Waller | 13b. MOTHER'S MAIDEN NAME Nancy Arrasmith | 14. NAME OF HUSBAND OR WIFE Deceased |
|-----------------------------------|---|--------------------------------------|

|   |                              |  |                             |
|---|------------------------------|--|-----------------------------|
| 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 Bertha Hirtler | ADDRESS Rt #4 St. Joseph Mo |
|---|------------------------------|--|-----------------------------|

|   |   |  |  |
|---|---|--|--|
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*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   |  | INTERVAL BETWEEN ONSET AND DEATH 6 mos |
|   | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic Carcinoma of face and head, and left eye.                                      |  |  |
|   | II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death. Semility. |  |  |

|                        |                                  |  |
|------------------------|----------------------------------|--|
| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 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) 191X |
|--|--|--|

|   |  |                            |
|---|--|----------------------------|
| 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 ~~observed~~ <sup>diagnosed</sup> the deceased ~~born~~ on 4/15, 1952, to \_\_\_\_\_, 19\_\_\_\_, that I last saw the deceased alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred at 9:50 A. m., from the causes and on the date stated above.

|   |                            |                          |
|---|----------------------------|--------------------------|
| 23a. SIGNATURE H F Mundy M.D. (Degree or title) | 23b. ADDRESS St Joseph Mo, | 23c. DATE SIGNED 7/23/52 |
|---|----------------------------|--------------------------|

|  |                   |  |   |
|--|-------------------|--|---|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24b. DATE 4/17/52 | 24c. NAME OF CEMETERY OR CREMATORY Agency Cemetery | 24d. LOCATION (City, town, or county) (State) Agency Mo |
|--|-------------------|--|---|

|   |                                    |       |   |                    |
|---|------------------------------------|-------|---|--------------------|
| DATE REC'D BY LOCAL REG. April 24, 1952 | REGISTRAR'S SIGNATURE Carl C. Cash | 446-C | FUNERAL DIRECTOR'S SIGNATURE John E. Pugh | ADDRESS 6054 Pryor |
|---|------------------------------------|-------|---|--------------------|

(Licensed Embalmer's Statement on Reverse Side)

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, ~~only~~.....

..... Student Embalmer No. ....  
working under my personal supervision.

Student .....  
Student Embalmer

Signed.....

*John E. Rupp*  
Licensed Embalmer No. *3986*  
P. O. Address *St. Joseph Mo*

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.