

FILED JUL 28 1952

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 23679

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 1000 Registrar's No. 768

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. LENGTH OF STAY (If this place) 82 yrs.	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Joseph		0117	
d. FULL NAME OF HOSPITAL OR INSTITUTION 1029 Douglas St.			d. STREET ADDRESS (If rural, give location) 1029 Douglas St.			
3. NAME OF DECEASED (Type or Print) a. (First) Clara b. (Middle) Elizabeth c. (Last) Ewing			4. DATE OF DEATH (Month) (Day) (Year) 7 20 1952			
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH 7 4 1870	9. AGE (In years last birthday) 82	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
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) St. Joseph - Mo.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13a. FATHER'S NAME Henry J. Bibbins		13b. MOTHER'S MAIDEN NAME Hannah McKittick		14. NAME OF HUSBAND OR WIFE Josh Ewing		
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 ADDRESS Thomas W. Crowley - 1828 Holman			
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) Rheumatic Heart Disease with Multiple Valve damage. ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Congestive Heart Failure DUE TO (c) Arteriosclerosis General			INTERVAL BETWEEN ONSET AND DEATH ? ? 14d	
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)		414X	
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 7-1, 1952, to 7-20, 1952, that I last saw the deceased alive on 7-19, 1952, and that death occurred at 2:25 P. m., from the causes and on the date stated above.						
23a. SIGNATURE (Degree or title) [Signature]		23b. ADDRESS 316 no 10 th		23c. DATE SIGNED 7-21-52		
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 7 23 1952	24c. NAME OF CEMETERY OR CREMATORY Oakland Cemetery	24d. LOCATION (City, town, or county) (State) St. Joseph, Mo.			
DATE REC'D BY LOCAL REG. July 22, 1952	REGISTRAR'S SIGNATURE Carl C. Casto		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Wm. H. Alexander St. Joseph, Mo.			

(Licensed Embalmer's Statement on Reverse Side)

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

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FEB 1 1954

**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 Wm H. Alexander

Licensed Embalmer No. 4450

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.