

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **4916**
Registrar's No. **205**

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

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

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, Mo.	c. LENGTH OF STAY (In this place) 3 months	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Joseph	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Joseph Hospital		d. STREET ADDRESS (If rural, give location) 5110 1/2 King Hill Ave	

3. NAME OF DECEASED (Type or Print) a. (First) May b. (Middle) _____ c. (Last) Montgomery			4. DATE OF DEATH (Month) (Day) (Year) 2 6 1953		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 2/14/1899	9. AGE (In years last birthday) 53	IF UNDER 1 YEAR Days 11 Hours 23
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Laundry	11. BIRTHPLACE (City and State or Foreign Country) Pottersville, Mo. (U)		12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME William Olmstead	13b. MOTHER'S MAIDEN NAME Victoria ?	14. NAME OF HUSBAND OR WIFE Gerge Montgomery
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. (If yes, give war or date of service) no	17. INFORMANT'S SIGNATURE OR NAME Josephine Sharp ADDRESS Milan Mo.
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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 Unknown
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Metastasis Carcinoma of Brain		Unknown
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Malignant Thyroid DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 193x		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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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 **2-3**, 19**53**, to **2-6**, 19**53**, that I last saw the deceased alive on **2-5**, 19**53**, and that death occurred at **2:30 P. m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Carl C. Casper M.D.	23b. ADDRESS Tootle Building St. Joseph, Mo.	23c. DATE SIGNED 2-10-53
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 2/10/53	24c. NAME OF CEMETERY OR CREMATORY Oakwood Cemetery	24d. LOCATION (City, town, or county) (State) Milan Mo
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DATE REC'D BY LOCAL REG. Feb 13, 1953	REGISTRAR'S SIGNATURE Carl C. Casper	25. FEDERAL DIRECTOR'S SIGNATURE John E. Ruff ADDRESS 6054 Pryor Ave
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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 E. [Signature]

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.