

THE HEALTH DEPARTMENT OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No. **4947**
 Registrar's No. **248**

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		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
a. COUNTY Buchanan	b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Joseph	c. LENGTH OF STAY (In this place) 5 mo 3 day	d. FULL NAME OF HOSPITAL OR INSTITUTION State Hospital no 2
a. STATE Missouri		b. COUNTY Lafayette	
c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Lexington		d. STREET ADDRESS (If rural, give location) 922 Highland Ave.	

3. NAME OF DECEASED (Type or Print)	a. (First) Bertha	b. (Middle) R.	c. (Last) Waddell	4. DATE OF DEATH (Month) (Day) (Year) Feb. 18, 1953
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5. SEX Female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH June 18 1881	9. AGE (In years last birthday) 71 - 8 MONTHS 2 DAYS	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	11. BIRTHPLACE (State or foreign country) Missouri	12. CITIZEN OF WHAT COUNTRY? U.S.A
10a. USUAL OCCUPATION		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE		12. CITIZEN OF WHAT COUNTRY?	

13a. FATHER'S NAME R. J. Russell	13b. MOTHER'S MAIDEN NAME Marie Berneburg	14. NAME OF HUSBAND OR WIFE G. B. Waddell
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. none	17. INFORMANT'S SIGNATURE OR NAME G. B. Waddell	ADDRESS Lexington 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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH ? ?
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic Myocarditis		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hypertension + arterio-sclerosis		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Senile Psychosis 443X			

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)	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 Jan 1, 1953, to Feb 18, 1953, that I last saw the deceased alive on Feb 18, 1953, and that death occurred at 12⁴⁵ p.m., from the causes and on the date stated above.

23a. SIGNATURE Forrest Thomas M.D.	23b. ADDRESS St Josephs Mo 1. State Hosp no 2	23c. DATE SIGNED 2/18/53
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24a. BURIAL, CREMATION, REMOVAL (Specify) removal	24b. DATE 2/18/1953	24c. NAME OF CEMETERY OR CREMATORY Lexington Mo.	24d. LOCATION (City, town, or county) (State) Lexington Mo.
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DATE REC'D BY LOCAL REG. Feb 26, 1953	REGISTRAR'S SIGNATURE Carl E. Casper	25. FUNERAL DIRECTOR'S SIGNATURE Heatow Brown	ADDRESS Funeral Home
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St. Joseph, Mo.

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.....

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working under my personal supervision.

Student Embalmer No.....

Signed.....
Student Embalmer

Signed W.E. Edmonston

Licensed Embalmer No. 4791

P. O. Address 314 So 10 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.