

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. **13322**FILED **APR 20 1953** REG. DIST. NO. **42** PRIMARY REG. DIST. NO. **1000** Registrar's No. **446**

|   |  |  |  |
|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Buchanan</b>  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE <b>Missouri</b> b. COUNTY <b>Buchanan</b> |  |
| b. CITY (If outside corporate limits, write RURAL and give township)<br>OR TOWN <b>St. Joseph</b> |  | c. CITY (If outside corporate limits, write RURAL and give township)<br>OR TOWN <b>St. Joseph</b>  |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Missouri Methodist Hospital</b>                        |  | d. STREET ADDRESS (If rural, give location)<br><b>2009 Olive Street</b>  |  |
| c. LENGTH OF STAY (In this place)<br><b>50 yrs</b>  |  | 8117   |  |

|   |  |             |  |                           |  |  |  |
|---|--|-------------|--|---------------------------|--|--|--|
| 3. NAME OF DECEASED<br>(Type or Print)<br>a. (First) <b>Metha</b> |  | b. (Middle) |  | c. (Last) <b>Inselman</b> |  | 4. DATE OF DEATH<br>(Month) (Day) (Year)<br><b>April 6, 1953</b> |  |
|---|--|-------------|--|---------------------------|--|--|--|

|   |  |                               |  |  |  |  |  |  |  |                                |  |  |  |
|---|--|-------------------------------|--|--|--|--|--|--|--|--------------------------------|--|--|--|
| 5. SEX <b>Female</b>  |  | 6. COLOR OR RACE <b>White</b> |  | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Married</b> |  | 8. DATE OF BIRTH<br><b>May 7, 1868</b> |  | 9. AGE (In years last birthday) <b>84</b>  |  | IF UNDER 1 YEAR<br>Months Days |  | IF UNDER 24 HRS.<br>Hours Min.             |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b> |  |                               |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>At home</b>                      |  |  |  | 11. BIRTHPLACE (City and State or Foreign Country)<br><b>Brooklyn, New York.</b> |  |                                |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b> |  |

|   |  |  |   |  |  |  |  |  |                                   |  |  |
|---|--|--|---|--|--|--|--|--|-----------------------------------|--|--|
| 13a. FATHER'S NAME<br><b>Unknown</b>  |  |  | 13b. MOTHER'S MAIDEN NAME<br><b>Unknown</b> |  |  | 14. NAME OF HUSBAND OR WIFE<br><b>Carl Inselmann</b>           |  |  |                                   |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b> |  |  | 16. SOCIAL SECURITY NO.<br><b>None</b>      |  |  | 17. INFORMANT'S SIGNATURE OR NAME<br><b>Mr. Carl Inselmann</b> |  |  | ADDRESS<br><b>St. Joseph, Mo.</b> |  |  |

|  |  |   |  |  |  |  |  |   |  |
|--|--|---|--|--|--|--|--|---|--|
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)  |  | MEDICAL CERTIFICATION   |  |  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH  |  |
| <p>*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.</p> |  | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Cerebral Vascular Hemorrhage</b>  |  |  |  |  |  | <b>sudden</b>   |  |
|  |  | ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.               |  |  |  |  |  | years   |  |
|  |  | DUE TO (b) <b>essential hypertension</b>  |  |  |  |  |  |   |  |
|  |  | DUE TO (c)  |  |  |  |  |  |   |  |
|  |  | II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death. |  |  |  |  |  | <b>7 days</b>   |  |
| 19a. DATE OF OPERATION   |  | 19b. MAJOR FINDINGS OF OPERATION<br><b>331X</b>   |  |  |  |  |  | 20. AUTOPSY?<br>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) (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 **March 30 1953**, to **April 6, 1953**, that I last saw the deceased alive on **April 6, 1953**, and that death occurred at **10:40 P.M.**, from the causes and on the date stated above.

|  |  |                   |  |  |  |                                    |  |
|--|--|-------------------|--|--|--|------------------------------------|--|
| 23a. SIGNATURE<br><b>Sharon E. Livingston M.D.</b> |  | (Degree or title) |  | 23b. ADDRESS<br><b>301 Illinois St. Joseph</b> |  | 23c. DATE SIGNED<br><b>4/8/53.</b> |  |
|--|--|-------------------|--|--|--|------------------------------------|--|

|  |  |                                  |  |   |  |   |  |
|--|--|----------------------------------|--|---|--|---|--|
| 24a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b> |  | 24b. DATE<br><b>Apr. 9, 1953</b> |  | 24c. NAME OF CEMETERY OR CREMATORY<br><b>Ashland Cemetery</b> |  | 24d. LOCATION (City, town, or county) (State)<br><b>St. Joseph, Missouri.</b> |  |
|--|--|----------------------------------|--|---|--|---|--|

|   |  |   |  |   |  |                                   |  |
|---|--|---|--|---|--|-----------------------------------|--|
| DATE REC'D BY LOCAL REG.<br><b>April 16, 1953</b> |  | REGISTRAR'S SIGNATURE<br><b>Kathleen M. Allison</b> |  | 25. FUNERAL DIRECTOR'S SIGNATURE<br><b>Maeisbroffer-Gleeman, Inc.</b> |  | ADDRESS<br><b>St. Joseph, Mo.</b> |  |
|---|--|---|--|---|--|-----------------------------------|--|

(Licensed Embalmer's Statement on Reverse Side)

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

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 *Edward P. Livingston*

Licensed Embalmer No. 3258 Missouri.

P. O. Address St. Joseph, Missouri.

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.