

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

20720

State File No.

0.300
0.48

FILED JUL 6 - 1953

BIRTH NO. _____ REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 1000 Registrar's No. 724

| | | | |
|--|--|--|--|
| 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 (In this place) 50 years | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Joseph 0117 | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION 2421 Francis St. Saxton Nursing Home | | d. STREET ADDRESS (If rural, give location) 2421 Francis St. 0 | |

| | | | | |
|--|------------|-------------|-----------|--|
| 3. NAME OF DECEASED (Type or Print) Dora | a. (First) | b. (Middle) | c. (Last) | 4. DATE OF DEATH (Month) (Day) (Year) June 28, 1953 |
| | | | | Brown |

| | | | | | | | | |
|-------------------------|----------------------------------|--|---|--|---------------------------|-------------------------|--------------------------|-------------------------|
| 5. SEX female | 6. COLOR OR RACE white | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed | 8. DATE OF BIRTH January 16, 1880 | 9. AGE (In years last birthday) 73 | IF UNDER 1 YEAR Months | IF UNDER 1 YEAR Days | IF UNDER 1 YEAR Hours | IF UNDER 1 YEAR 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 (City and State or Foreign Country) Stewartsville, Missouri | 12. CITIZEN OF WHAT COUNTRY? USA |
|---|--|--|--|

| | | |
|---|---|---|
| 13a. FATHER'S NAME D. G. Saunders | 13b. MOTHER'S MAIDEN NAME Sarah Jane McDaniel | 14. NAME OF HUSBAND OR WIFE George C. |
|---|---|---|

| | | | |
|---|----------------------------------|--|---------|
| 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. _____ | 17. INFORMANT'S SIGNATURE OR NAME Harry Saunders, 3219 Lafayette, St. Joseph, Mo | ADDRESS |
|---|----------------------------------|--|---------|

| | | | |
|---|---|--|---|
| 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. | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Vascular accident | | INTERVAL BETWEEN ONSET AND DEATH 2 days |
| | ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arteriosclerosis | | unk. |
| | DUE TO (c) | | |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Metastatic carcinoma breast 6 yrs. | | | |

| | | |
|------------------------|--|---|
| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION 331xH | 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) |
|--|--|---|

| | | |
|---|--|----------------------------|
| 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 June 28, 1953 to June 28, 1953, that I last saw the deceased alive on June 28, 1953 and that death occurred at 3:45 pm from the causes and on the date stated above.

| | | |
|---|--|------------------------------------|
| 23a. SIGNATURE (Degree or title) Sharon E. Loggner M.D. | 23b. ADDRESS 301 Main St. City | 23c. DATE SIGNED 6/28/53 |
|---|--|------------------------------------|

| | | | |
|--|------------------------------|---|--|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) burial | 24b. DATE 7/1/1953 | 24c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery | 24d. LOCATION (City, town, or county) (State) St. Joseph, Missouri |
|--|------------------------------|---|--|

| | | | | |
|---|---|-----|---|-----------------------------------|
| DATE REC'D BY LOCAL REG. July 2, 1953 | REGISTRAR'S SIGNATURE Kathleen M. Allison | 487 | 25. FUNERAL DIRECTOR'S SIGNATURE Heaton-Bowman Funeral Home | ADDRESS St. Joseph, Mo. |
|---|---|-----|---|-----------------------------------|

(Licensed Embalmer's Statement on Reverse Side)

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

8861 08 108

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 _____

Eugene Wood

Licensed Embalmer No. 3804

P. O. Address 319 Saloth, 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.