

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

23994

State File No. \_\_\_\_\_

FILED JUL 20 1953

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 1000 Registrar's No. 797

1. PLACE OF DEATH a. COUNTY <b>Buchanan</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Buchanan</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Joseph</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Rural-Washington Twsp.</b>	
c. LENGTH OF STAY (in this place) <b>1 week</b>		d. STREET ADDRESS (If rural, give location) <b>RR #6</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>St. Joseph's Hospital</b>			

3. NAME OF DECEASED (Type or Print) <b>LUELLA</b>			a. (First)	b. (Middle)	c. (Last) <b>SINGLETON</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>July 10, 1953</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>		8. DATE OF BIRTH <b>Sept 26, 1875</b>		9. AGE (In years last birthday) <b>77</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housekeeper</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (City and State or Foreign Country) <b>Winterset, Iowa</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	

13a. FATHER'S NAME <b>Edward Atkinson</b>		13b. MOTHER'S MAIDEN NAME <b>Catherine Sparks</b>		14. NAME OF HUSBAND OR WIFE <b>John T. Singleton</b>	
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT'S SIGNATURE OR NAME MO. ADDRESS <b>Harold Singleton, RR #6, St. Joseph,</b>	
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  <i>*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>		MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Cerebral Vascular Accident</b>		DUE TO (b) <b>Essential Hypertension</b>				Unknown	
ANTECEDENT CAUSES <i>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</i>		DUE TO (c)					
II. OTHER SIGNIFICANT CONDITIONS <i>Conditions contributing to the death but not related to the disease or condition causing death.</i>							

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <b>331X</b>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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 July 6, 1953, to July 10, 1953, that I last saw the deceased alive on July 8, 1953 and that death occurred at 4:00A m., from the causes and on the date stated above.

23a. SIGNATURE <b>Marion E. Wagner M.D.</b> (Degree or title)		23b. ADDRESS <b>301 Illinois Ave., City</b>		23c. DATE SIGNED <b>7-15-53</b>	
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		24b. DATE <b>July 13, 1953</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Mt. Auburn Cem</b>		24d. LOCATION (City, town, or county) (State) <b>St. Joseph, Mo.</b>	
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DATE REC'D BY LOCAL REG. <b>July 18, 1953</b>		REGISTRAR'S SIGNATURE <b>Lothar M. Allison</b>		FUNERAL DIRECTOR'S SIGNATURE <b>John E. Rupp</b>		ADDRESS <b>St. Joseph, Mo.</b>	
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(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 *John E. Rupp* .....

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.