

**THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH**

27787

State File No.

FILED SEP 8 - 1953 REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 1000 Registrar's No. 947

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

3. NAME OF DECEASED (Type or Print)	a. (First) <u>Louise</u>	b. (Middle) <u>Josephine</u>	c. (Last) <u>Hancock</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>August 30, 1953</u>
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>4-22-1881</u>	9. AGE (In years last birthday) <u>72</u>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>St. Joseph, Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13a. FATHER'S NAME <u>John Porta</u>	13b. MOTHER'S MAIDEN NAME <u>Dominica Lamanta</u>	14. NAME OF HUSBAND OR WIFE <u>John W. Hancock</u>
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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) <u>No</u>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Aurthur Hancock, Chicago, Ill.</u>	ADDRESS
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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, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) <u>Cerebral Vascular Accident</u>		
	ANTECEDENT CAUSES		
	DUE TO (b) <u>Diabetes Mellitus</u>		<u>Unknown</u>
	DUE TO (c) <u>Malignant Hypertension</u>		<u>Ukn.</u>
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	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) <u>331X</u>
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 12-22, 1949, to 8-31, 1953, that I last saw the deceased alive on 8/29, 1953, and that death occurred at 12:15 Am., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Dr. W. W. Allison M.D.</u>	23b. ADDRESS <u>Tootle Building St. Joseph, Mo.</u>	23c. DATE SIGNED <u>9/1/53</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>9-2-1953</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>St. Joseph, Missouri</u>
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DATE REC'D BY LOCAL REG. <u>Sept 2, 1953</u>	REGISTRAR'S SIGNATURE <u>Kathleen M. Allison</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>John [Signature]</u>	ADDRESS <u>St. Joseph, Mo.</u>
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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*

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.