

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **35080**

FILED NOV 13 1953

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **42** PRIMARY REG. DIST. NO. **1000** Registrar's No. **1166**

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

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>St. Joseph</b>	
c. LENGTH OF STAY (in this place) <b>50 years</b>		0117 0	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>3528 Lafayette St.</b>		d. STREET ADDRESS <b>3528 Lafayette St.</b>	
3. NAME OF DECEASED a. (First) <b>Jennie</b> (Type or Print)		b. (Middle) <b>Limback</b> c. (Last)	
4. DATE OF DEATH <b>Nov. 7, 1953</b>		(Month) (Day) (Year)	
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>January 10, 1865</b>
9. AGE (in years last birthday) <b>88</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>	11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13a. FATHER'S NAME <b>UNK. Wayman</b>		13b. MOTHER'S MAIDEN NAME <b>unk.</b>	
14. NAME OF HUSBAND OR WIFE <b>Herman F.</b>		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 <b>Walter Limback, 3528 Lafayette St. Joseph, Mo.</b>	
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, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Carcinoma, site undetermined</b> INTERVAL BETWEEN ONSET AND DEATH <b>2-3 yrs</b> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Erythraemic leucemia</b> <b>2 1/2 mo.</b> DUE TO (c) <b>1991</b>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>Arteriosclerotic cardiovascular disease</b>		19. DATE OF OPERATION <b>10/27/53</b>	
19b. MAJOR FINDINGS OF OPERATION <b>Melanotic adenocarcinoma of irregular node</b>		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) (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 <b>8-31, 1953, to 11-7, 1953</b> , that I last saw the deceased alive on <b>11-5, 1953</b> and that death occurred at <b>8:30 p. m.</b> , from the causes and on the date stated above.			
23a. SIGNATURE <b>Gordon C. Bauer, M.D.</b>		23b. ADDRESS <b>902 Edmund, City</b>	
23c. DATE SIGNED <b>11/10/53</b>		24a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	
24b. DATE <b>11/10/1953</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Memorial Park</b>	
24d. LOCATION (City, town, or county) (State) <b>St. Joseph, Mo.</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Walter Limback</b>	
25. ADDRESS <b>St. Joseph, Mo.</b>		DATE REC'D BY LOCAL REG. <b>Nov 12, 1953</b>	
REGISTRAR'S SIGNATURE <b>Kathleen M. Allison</b>		4857	

**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 *William Galding* \_\_\_\_\_

Licensed Embalmer No. *4535* \_\_\_\_\_

P. O. Address *3195 11th St. N. Wash. D.C.* \_\_\_\_\_

**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.