

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 38300

FILED DEC 7 1953

BIRTH NO. _____		REG. DIST. NO. <u>42</u>		PRIMARY REG. DIST. NO. <u>1000</u>		Registrar's No. <u>1243</u>	
1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Andrew</u>			
b. CITY (If outside corporate limits, write RURAL and give township) <u>St. Joseph</u>		c. LENGTH OF STAY (In this place) <u>6 days</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Bolckow</u>		d. STREET ADDRESS (If rural, give location) <u>2029</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Missouri Methodist Hosp</u>				d. STREET ADDRESS (If rural, give location)			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Laura</u> b. (Middle) <u>Catherine</u> c. (Last) <u>Gressly</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>11-30-1953</u>				
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>July 8 1870</u>		9. AGE (In years last birthday) <u>83</u>	IF UNDER 1 YEAR Months <u>4</u> Days <u>22</u>	IF UNDER 1 Wks. Hours _____ Mins. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (City and State or Foreign Country) <u>Bolckow Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13a. FATHER'S NAME <u>William D Roberts</u>			13b. MOTHER'S MAIDEN NAME <u>Lydia Anderson</u>		14. NAME OF HUSBAND OR WIFE <u>Adam E Gressly</u>		
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 ADDRESS <u>Wm Gressly - Bolckow mo</u>			
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Intestinal Obstruction</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Intestinal adhesions</u> DUE TO (c) <u>Demoid cyst of ovary</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>216X</u>					INTERVAL BETWEEN ONSET AND DEATH <u>10 day</u> <u>Year</u>
19a. DATE OF OPERATION <u>11-28-53</u>		19b. MAJOR FINDINGS OF OPERATION <u>Demoid cyst - degenerating + causing ashenia</u>					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) m.		21e. INJURY OCCURRED WHILE AT <input type="checkbox"/> 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 <u>11-25-</u> , <u>1953</u> , to <u>11-30</u> , <u>1953</u> , that I last saw the deceased alive on <u>11-30-</u> , <u>1953</u> , and that death occurred at <u>10:20 a.m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Paul Jorgensen M.D.</u>				23b. ADDRESS <u>St. Joseph Mo</u>		23c. DATE SIGNED <u>12-1-53</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24b. DATE <u>12-1-1953</u>	24c. NAME OF CEMETERY OR CREMATOR <u>Bolckow</u>		24d. LOCATION (City, town, or county) (State) <u>Bolckow Mo</u>		
DATE REC'D BY LOCAL REG. <u>Dec 2, 1953</u>		REGISTRAR'S SIGNATURE <u>Kathleen M. Allison</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Breit Funeral Home Savannah Mo</u>			

(Licensed Embalmer's Statement on Reverse Side)

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

DEC 28 1939

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 E. C. Breit

Licensed Embalmer No. 2650

P. O. Address Savannah, Ga

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.