

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

42123

State File No.

S. No. 300
v. 10. 48

FILED JAN 11 1954

BIRTH NO. _____ REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 1000 Registrar's No. 1357

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>Buchanan</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Joseph</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural Center Twp. 0110</u>	
c. LENGTH OF STAY (in this place) <u>8 yrs.</u>		d. STREET ADDRESS (If rural, give location) <u>R.F.D. # 6, St. Joseph</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>General D.O. Hospital</u>			

3. NAME OF DECEASED (Type or Print) <u>BERNADENA HERRING</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>12 28 1953</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>4-20-1924</u>		9. AGE (In years last birthday) <u>29</u>
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 <u>Home</u>	11. BIRTHPLACE (State or foreign country) <u>Nevada, Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>

13a. FATHER'S NAME <u>Guy R. Son</u>		13b. MOTHER'S MAIDEN NAME <u>Landora Baue</u>		14. NAME OF HUSBAND OR WIFE <u>William Herring</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>William Herring, R.F.D. # 6 St. Joseph, Mo.</u>	

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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>TOXEMIA OF PREGNANCY</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 MONTHS</u>
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>STREPT THROAT INFECTION</u>			<u>3 WEEKS</u>
		DUE TO (c) <u>HEPATITIS</u>			<u>2 MONTHS</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"/>	
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 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 6-20-1953, to 12-28-1953, that I last saw the deceased alive on 12-28-1953 and that death occurred at 9:35 P.M., from the causes and on the date stated above.

23a. SIGNATURE <u>A. E. Zacher</u>		(Degree or title) <u>D.O.</u>		23b. ADDRESS <u>322 ILLINOIS AVE. CITY</u>		23c. DATE SIGNED <u>12-30-53</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>12-30-1953</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Odd Fellows Public</u>		24d. LOCATION (City, town, or county) (State) <u>St. Joseph, Mo.</u>	
DATE REC'D BY LOCAL REG. <u>Jan 4, 1954</u>		REGISTRAR'S SIGNATURE <u>Robert M. Allison</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Phred Stupp</u>		ADDRESS <u>St. Joseph, Mo.</u>	

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

STATEMENT BY LICENSED EMBALMER

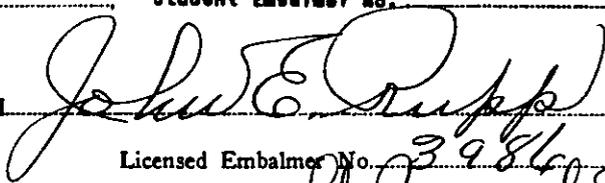
I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed _____



Licensed Embalmer No. _____

P. O. Address _____

3986
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.