

STANDARD CERTIFICATE OF DEATH

State File No. **4038**BIRTH NO. _____ REG. DIST. NO. **42** PRIMARY REG. DIST. NO. **1000** Registrar's No. **255**

FILED MAR 15 1954

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

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Buchanan	
b. CITY (If outside corporate limits, write RURAL and give town) St. Joseph		c. CITY (If outside corporate limits, write RURAL and give township) St. Joseph	
c. LENGTH OF STAY (in this place) 60 yrs		d. STREET ADDRESS (If rural, give location) 1917 St. Joseph Avenue	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Joseph's Hospital			
3. NAME OF DECEASED a. (First) EMMA		b. (Middle) KATHERINE	
c. (Last) FROIDEVAUX		4. DATE OF DEATH (Month) March (Day) 3 (Year) 1954	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH March 18, 1886
9. AGE (In years last birthday) 67		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home	
11. BIRTHPLACE (State or foreign country) Leona, Kansas		12. CITIZEN OF WHAT COUNTRY? U S A	
10b. KIND OF BUSINESS OR INDUSTRY Home			
13a. FATHER'S NAME Christ Wagner		13b. MOTHER'S MAIDEN NAME Katie Cook	
14. NAME OF HUSBAND OR WIFE Leon Froidevaux			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT'S SIGNATURE OR NAME Claude Madison Adm.		ADDRESS St. Joseph, Mo.	
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hemorrhage, cerebral	
		INTERVAL BETWEEN ONSET AND DEATH 3 days	
		ANTECEDENT CAUSES DUE TO (b) Arteriosclerosis, general	
		DUE TO (c) _____	
		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 331 X	
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)		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 3/1/54 , 19__, to 3/3/54 , 19__, that I last saw the deceased alive on 3/2/54 , 19__, and that death occurred at 7:00A m., from the causes and on the date stated above.			
23a. SIGNATURE Allen L. Lerman (Degree or title) M. D.		23b. ADDRESS 706 Francis, St. Joseph, Mo.	
23c. DATE SIGNED 3/5/54			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE Mar. 5, 1954	
24c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery		24d. LOCATION (City, town, or county) (State) St. Joseph - Missouri	
DATE REC'D BY LOCAL REG. Mar 11, 1954		REGISTRAR'S SIGNATURE Notches M. Allison	
5. FUNERAL DIRECTOR'S SIGNATURE Stoney Funeral Home		ADDRESS St. Joseph, Mo.	

(Licensed Embalmer's Statement on Reverse Side)

MAY 11 1955

JUN 20 1955

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.....

working under my personal supervision.

Student Embalmer No.....

Signed *Charles E. Bennett*

Signed.....
Student Embalmer

Licensed Embalmer No. *H674*

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.