

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

4070

State File No.

BIRTH NO. **FILED FEB 22 1954** REG. DIST. NO. **42** PRIMARY REG. DIST. NO. **1000** Registrar's No. **189**

2

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

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).	
a. COUNTY <u>Luchanan</u>		a. STATE <u>Missouri</u> b. COUNTY <u>Clay</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>Excelsior Springs</u>	
c. LENGTH OF STAY (in this place) <u>5 1/2 - 4 m - 12 days</u>		d. STREET ADDRESS (If rural, give location) <u>Rural</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>State Hospital no 2</u>			
3. NAME OF DECEASED			4. DATE OF DEATH (Month) (Day) (Year)
a. (First) <u>Zerakda</u> b. (Middle) <u>Maybe</u> c. (Last)			<u>Feb 16 - 1954</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>never married</u>	8. DATE OF BIRTH <u>not given</u>
9. AGE (In years last birthday) <u>82</u>	IF UNDER 1 YEAR Months Days Hours Min.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>	10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) <u>Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>not given</u>		13b. MOTHER'S MAIDEN NAME <u>not given</u>	
14. NAME OF HUSBAND OR WIFE <u>none</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. D.A. Geis</u>		ADDRESS <u>Excelsior Spgs Mo R 7 L</u>	
MEDICAL CERTIFICATION			
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* <u>Carcinoma of stomach</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>
ANTECEDENT CAUSES			
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.			
DUE TO (b) <u>arteriosclerosis</u>			
DUE TO (c)			
II. OTHER SIGNIFICANT CONDITIONS			
Conditions contributing to the death but not related to the disease or condition causing death. <u>Dementia Praxey Nephrosenitis typh</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		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 <u>Jan 1, 1954</u> , to <u>Feb 16, 1954</u> , that I last saw the deceased alive on <u>Feb 16, 1954</u> , and that death occurred at <u>3:57 p.m.</u> , from the causes and on the date stated above.			
23a. SIGNATURE <u>Dr. Carlos E. Braun M.D.</u>		23b. ADDRESS <u>State Hospital no 2 St Joseph Mo</u>	
23c. DATE SIGNED <u>2/16-54</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		24b. DATE <u>2/17/1954</u>	
24c. NAME OF CEMETERY OR CREMATORY <u>City Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>St Joseph, Mo.</u>	
DATE REC'D BY LOCAL REG. <u>Feb 20, 1954</u>		REGISTRAR'S SIGNATURE <u>Eather M. Allison</u>	
25. FUNERAL DIRECTOR'S SIGNATURE <u>Heaton Bowman</u>		ADDRESS <u>St Joseph Mo</u>	

(Licensed Embalmer's Statement on Reverse Side)

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 Spidney* _____

Licensed Embalmer No. *4535* _____

P. O. Address *319 S. 1st St. Memphis, Tenn.* _____

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.