

FILED MAY 18 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **14984**

BIRTH NO. _____ REG. DIST. NO. **42** PRIMARY REG. DIST. NO. **1000** Registrar's No. **474**

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Kansas b. COUNTY Doniphan	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Joseph	c. LENGTH OF STAY (in this place) 1 day	c. CITY OR TOWN Severance	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Joseph's Hospital		e. STREET ADDRESS (If rural, give location) *****	

3. NAME OF DECEASED (Type or Print) a. (First) Theresia b. (Middle) Libel c. (Last) Libel		4. DATE OF DEATH (Month) (Day) (Year) May 3, 1954	
5. SEX female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed	8. DATE OF BIRTH Nov. 28, 1879
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housekeeping		10b. KIND OF BUSINESS OR INDUSTRY own home	9. AGE (in years last birthday) 74 If UNDER 1 YEAR: Months _____ Days _____ If UNDER 24 HRS.: Hours _____ Min. _____
11a. BIRTHPLACE (City and State or Foreign Country) Hanover, Kansas		12. CITIZEN OF WHAT COUNTRY? USA	

13a. FATHER'S NAME H. G. Laverenz	13b. MOTHER'S MAIDEN NAME unknown	14. NAME OF HUSBAND/OR WIFE J. J. Libel
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	16. SOCIAL SECURITY NO. none	17. INFORMANT'S SIGNATURE OR NAME ADDRESS J.T. Libel, Severance, Kansas

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		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cancer of Stomach		unknown
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Diabetes Mellitus		10 yrs
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)	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 **2-10, 1954**, to **Death, 1954**, that I last saw the deceased alive on **May 3, 1954**, and that death occurred at **5-3 05P. m.**, from the causes and on the date stated above.

22a. SIGNATURE (Degree or title) Emerson Glader M.D.	22b. ADDRESS Stanton, Kans	22c. DATE SIGNED 5-5-54
24a. BURIAL, CREMATION, REMOVAL (Specify) removal	24b. DATE 5/11/54	24c. NAME OF CEMETERY OR CREMATORY Highland, Kansas

DATE REC'D BY LOCAL REG. May 11, 1954	REGISTRAR'S SIGNATURE Kathleen M Allison	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Stanton, Bowman St Joseph Mo
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(Licensed Embalmer's Statement on Reverse Side)

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.....
Signature of Student Embalmer

Signed..... *William Spalding*

Licensed Embalmer No... *450*

P. O. Address *395 17th St*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.