No. 300
10.46

FILED AUG 16 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 26353

BIRTH NO. _____ REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 1000 Registrar's No. 864

1. PLACE OF DEATH
a. COUNTY: Buchanan
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Joseph
c. LENGTH OF STAY (In this place): 63 yrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Missouri Methodist Hospt.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY: Buchanan
c. CITY OR TOWN: St. Joseph
d. Is Residence within limits of a city or incorporated town? Yes ☒ No ☐
e. STREET ADDRESS (If rural, give location): 817 East Hyde Park Ave., 817

3. NAME OF DECEASED (Type or Print)
a. (First): BEULAH
b. (Middle): MAE
c. (Last): ROCKWELL

4. DATE OF DEATH (Month) (Day) (Year): 8/5/54

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: 3/2/1891

9. AGE (In years last birthday): 63 | If under 1 year: Months, Days | If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Home making

11. BIRTHPLACE (City and State or Foreign Country): St. Joseph, Mo.

12. CITIZEN OF WHAT COUNTRY?: USA

13a. FATHER'S NAME: James W. Elliott

13b. MOTHER'S MAIDEN NAME: Mary Ellen Cottrill

14. NAME OF HUSBAND OR WIFE: John E. Rockwell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: Unknown

17. INFORMANT'S SIGNATURE OR NAME: John E. Rockwell
ADDRESS: 817 E. Hyde Park, 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, asthenia, etc. It means the disease, injury or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Acute Pulmonary Embolism — INTERVAL BETWEEN ONSET AND DEATH: 5 1/2 m

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Thrombosis L. Leg Veins & Vena Cava. — 4 wks
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
Myocardial decompensation yrs

19a. DATE OF OPERATION: 9/4/54
19b. MAJOR FINDINGS OF OPERATION: 463X
20. AUTOPSY? YES ☐ NO ☒

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 ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 3-3-, 1949 *to* 8-5-, 1954, *that I last saw the deceased alive on* 8-5-, 1954, *and that death occurred at* 11:00 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE: R. W. Kieber, M.D. (Degree or title)
23b. ADDRESS: Kirkpatrick Bldg. St. Joseph
23c. DATE SIGNED: 8/6/54

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 8/9/54
24c. NAME OF CEMETERY OR CREMATORY: Memorial Park Cemetery
24d. LOCATION (City, town, or county) (State): St. Joseph, Mo.

DATE REC'D BY LOCAL REG.: Aug 9, 1954
REGISTRAR'S SIGNATURE: Esther M. Allison Dep. Reg.
25. FUNERAL DIRECTOR'S SIGNATURE: D. O. Gray
ADDRESS: CLARK FUNERAL HOME St. Joseph, Mo.

485-0 (Licensed Embalmer's Statement on Reverse Side)

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

Consult with 493-18022J - 498-24-7073 493-24-7073

Dr Kirk
Kirkpat

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was emb

by me, or by ....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed.....

Licensed Embalmer No. 46.

P. O. Address St. Jose

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (F
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.