

FILED NOV 8 - 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

33073

State File No.

BIRTH NO. _____ REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 1000 Registrar's No. 1137

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 OR TOWN <u>St. Joseph</u>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (In this place) <u>55 years</u>		f. STREET ADDRESS (If rural, give location) <u>2325 S. 15th St.</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Josephs Hospital</u>			

3. NAME OF DECEASED (Type or Print)	a. (First) <u>Mary</u>	b. (Middle) <u>Ann</u>	c. (Last) <u>Habig</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>October 28, 1954</u>
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5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, <u>married</u>	8. DATE OF BIRTH <u>November 7, 1874</u>	9. AGE (In years last birthday) <u>79</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
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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>own home</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Hanover, Kansas</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13a. FATHER'S NAME <u>Jacob Straub</u>	13b. MOTHER'S MAIDEN NAME <u>Emma Weber</u>	14. NAME OF HUSBAND OR WIFE <u>Fred M.</u>
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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 <u>Fred Habig, 2325 S. 15th, St. Joseph, Mo.</u>	ADDRESS _____
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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, ashenia, etc. It means the disease, injury, or complication which caused death.</i>	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>Few Minutes</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Pulmonary Embolism</u>		
ANTECEDENT CAUSES		DUE TO (b) <u>Thrombophlebitis left leg</u>	
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (c) <u>Coronary Sclerosis</u>	
II. OTHER SIGNIFICANT CONDITIONS		<u>Arteriosclerosis General</u>	
Conditions contributing to the death but not related to the disease or condition causing death.		<u>Arteriosclerotic Heart Disease</u>	

19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION <u>4/201</u>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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) _____
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) _____	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? _____
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22. I hereby certify that I attended the deceased from 10-16, 1954, to 10-28, 1954, that I last saw the deceased alive on 10-28, 1954, and that death occurred at 9:35 a. m., from the causes and on the date stated above.

23a. SIGNATURE <u>W. M. B. Robinson</u> (Degree or title) _____	23b. ADDRESS <u>316 W. 10th City</u>	23c. DATE SIGNED <u>10-28-54</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	24b. DATE <u>10/30/1954</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>St. Joseph, Missouri</u>
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DATE REC'D BY LOCAL REG. <u>Nov 3, 1954</u>	REGISTRAR'S SIGNATURE <u>Kathleen M. Allison</u> <u>485</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Hester Bowman</u> ADDRESS <u>St. Joseph, Mo.</u>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

Alv Street

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 Billie Clay Gonder Student Embalmer No. 510 working under my personal supervision..

Student Billie Clay Gonder
Signature of Student Embalmer

Signed William Spalding
Licensed Embalmer No. 4525

P. O. Address 3195 1/2 St. N. S.W.

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.