

FILED OCT 25 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

33114

State File No.

BIRTH NO. _____ REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 1000 Registrar's No. 1103

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 v</u>		c. LENGTH OF STAY (In this place) <u>33 yrs.</u>	c. CITY OR TOWN <u>St. Joseph</u>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>2517 Felix Street</u>		e. STREET ADDRESS (If rural, give location) <u>2517 Felix Street</u>	

3. NAME OF DECEASED (Type or Print) <u>Eleanor</u>	a. (First)	b. (Middle)	c. (Last) <u>Packwood</u>	4. DATE OF DEATH <u>October 17, 1954.</u>
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>March 16, 1905</u>	9. AGE (In years last birthday) <u>49</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 10 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>At home</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Bisbee, Arizona.</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13a. FATHER'S NAME <u>Frank R. Harrington</u>	13b. MOTHER'S MAIDEN NAME <u>Nancy Geddes</u>	14. NAME OF HUSBAND OR WIFE <u>S. F. Packwood</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give way or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Samuel F. Packwood</u>	ADDRESS <u>St. Joseph, Mo.</u>
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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 <u>6 months</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Carcinoma toxi</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Carcinoma of ovaries</u> DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>175X</u>			

19a. DATE OF OPERATION <u>4-20-54</u>	19b. MAJOR FINDINGS OF OPERATION <u>Carcinoma of ovaries & metastasis to liver</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) m.	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 4-21, 1953, to 10-17, 1954, that I last saw the deceased alive on 10-17, 1954, and that death occurred at 3:33 P. m., from the causes and on the date stated above.

23a. SIGNATURE <u>S. E. Perros M.D.</u>	(Degree or title) _____	23b. ADDRESS <u>St. Joseph Mo.</u>	23c. DATE SIGNED <u>10-19-54</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>Oct. 19, 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>Oct 22, 1954</u>	REGISTRAR'S SIGNATURE <u>Kathleen M. Allison</u>	485	25. FUNERAL DIRECTOR'S SIGNATURE <u>Precedhoffe-Flanagan</u>	ADDRESS <u>St. Joseph, Mo.</u>
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(Licensed Embalmer's Statement on Reverse Side)

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

JAN 10 1957

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.....*Raymond H. Herlihy*.....

Licensed Embalmer No.....441.....

P. O. Address St. Joseph, I.....

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.