

FILED DEC 27 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

40148

State File No.

42

1000

1329

BIRTH NO. _____ REG. DIST. NO. _____ PRIMARY REG. DIST. NO. _____ Registrar's No.

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Buchanan	
b. CITY (If outside corporate limits, write RURAL and give township) St. Joseph	c. LENGTH OF STAY (in this place) 34 yrs.	c. CITY OR TOWN St. Joseph	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 (If not in hospital or institution, give street address or location) St. Joseph's Hospital		f. STREET ADDRESS (If rural, give location) 2422 So. 6th St. 0117 0	

3. NAME OF DECEASED (Type or Print)	a. (First) LYDIA	b. (Middle)	c. (Last) CRUZ	4. DATE OF DEATH (Month) (Day) (Year) Dec. 18, 1954
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Aug. 3, 1887	9. AGE (In years last birthday) 67	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) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (City and State or Foreign Country) Penjamo Gto., Mexico	12. CITIZEN OF WHAT COUNTRY? Nat. USA
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13a. FATHER'S NAME Unknown	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Florentino Cruz
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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) NO	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME Alfonzo Cruz, 2422 So. 6th St., City	ADDRESS
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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, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH Unknown
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Myocardial Insufficiency</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		Unknown	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	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 8/13, 1951, to 12/18, 1954, that I last saw the deceased alive on 12/18, 1954, and that death occurred at 9:40A m., from the causes and on the date stated above.

23a. SIGNATURE (Type or Print) <u>Thy Redmond MD</u>	23b. ADDRESS St. Joseph, Mo	23c. DATE SIGNED 12/20/54
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 12-20-1954	24c. NAME OF CEMETERY OR CREMATORY Mt. Olivet	24d. LOCATION (City, town, or county) (State) St. Joseph, Missouri
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DATE REC'D BY LOCAL REG. Dec 23, 1954	REGISTRAR'S SIGNATURE <u>Kathleen M. Allison</u>	485	25. FUNERAL DIRECTOR'S SIGNATURE <u>John Rupp</u>	ADDRESS St. Joseph, Mo.
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(Licensed Embalmer's Statement on Reverse Side)

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

0.300
0.48

NOV 6

1958

SEP 5

1958

FEB 16 1955

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 *Allan E. Boya*.....

Licensed Embalmer No. *479*

P. O. Address *St. Joseph*

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.