

FILED NOV 7 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

32291

State File No.

BIRTH NO. _____ REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 1000 Registrar's No. 1153

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). ---a.-STATE Missouri b. COUNTY Andrew	
b. CITY (If outside corporate limits, write RURAL and give OR TOWN St. Joseph)	c. LENGTH OF STAY (in this place) township) 8 days	c. CITY OR TOWN Rochester	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION General Hospital (Osteo.)		e. STREET ADDRESS (If rural, give location) 0020	

3. NAME OF DECEASED (Type or Print)	a. (First) FRANCES	b. (Middle) IDA	c. (Last) KRULL	4. DATE OF DEATH (Month) (Day) (Year) Oct. 27, 1955
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5. SEX female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH 1899 June 23, 1899	9. AGE (In years last birthday) 56	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 own home		11. BIRTHPLACE (City and State or Foreign Country) Rochester, Missouri		12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME Francis A. Wells	13b. MOTHER'S MAIDEN NAME Ida Morrison	14. NAME OF HUSBAND OR WIFE Julius R.
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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 Mr. J. R. Krull, Rochester, Missouri	ADDRESS Rochester, Missouri
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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) Grade IV adenocarcinoma		
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION 10/21/55	19b. MAJOR FINDINGS OF OPERATION Adenocarcinoma of omentum, intestines, peritoneum, etc.	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) Rochester township, Andrew, Mo.
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? _____

22. I hereby certify that I attended the deceased from Sept. 1944 to Oct. 27, 1955, that I last saw the deceased alive on Oct. 27, 1955, and that death occurred at 11:35a m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) W. Maxwell	23b. ADDRESS D.O. 1307 W. Main, Savannah, Mo.	23c. DATE SIGNED 10/28/55
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24a. BURIAL, CREMATION, REMOVAL (Specify) burial	24b. DATE 10/29/1955	24c. NAME OF CEMETERY OR CREMATORY Savannah Cemetery	24d. LOCATION (City, town, or county) (State) Savannah, Missouri
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DATE REC'D BY LOCAL REG. Nov 1, 1955	REGISTRAR'S SIGNATURE Kathleen M. Allison	485	25. FUNERAL DIRECTOR'S SIGNATURE Newton - Bowman	ADDRESS St Joseph, Mo.
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(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNEADING 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 *Billie C. Londer*

Licensed Embalmer No. *490*

P. O. Address *St. Joe*

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.