

FILED DEC 28 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

39762

State File No.

BIRTH NO. _____		REG. DIST. NO. <u>42</u>		PRIMARY REG. DIST. NO. <u>1000</u>		Registrar's No. <u>1343</u>	
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 OR TOWN <u>St. Joseph</u>		c. LENGTH OF STAY (in this place) <u>2 months</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"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>228 W. Valley St.</u>				e. STREET ADDRESS (If rural, give location) <u>228 W. Valley St.</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Bessie</u>			b. (Middle) <u>A</u>		c. (Last) <u>Tritten</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Dec. 15, 1955</u>
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>Oct. 11, 1910</u>		9. AGE (In years last birthday) <u>45</u>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.
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>Couglass County, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>William J. Johnson</u>			13b. MOTHER'S MAIDEN NAME <u>Maude A. Shipman</u>		14. NAME OF HUSBAND OR WIFE <u>Herman Tritten</u>		
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>491-24-8676</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS: <u>Herman Tritten 228 W. Valley St. City</u>			
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) <u>Carcinoma of Fallopian Tubes with Metastasis</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) <u>175X</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Intestinal Obstruction</u>				INTERVAL BETWEEN ONSET AND DEATH <u>June 17, 1952</u>	
19a. DATE OF OPERATION <u>June 17, 1952</u>		19b. MAJOR FINDINGS OF OPERATION <u>Carcinoma of left Fallopian Tube</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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)		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 <u>Sept 13, 1954</u> , to <u>Dec 16, 1955</u> , that I last saw the deceased alive on <u>Dec 16, 1955</u> , and that death occurred at <u>8:15 p.m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Edw. S. Reed M.D.</u>				23b. ADDRESS <u>824 Edmond St. City</u>		23c. DATE SIGNED <u>Dec 16, 1955</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Dec. 17, 55</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park Cem.</u>		24d. LOCATION (City, town, or county) (State) <u>St. Joseph, Mo.</u>		
DATE REC'D BY LOCAL REG. <u>Dec 23, 1955</u>		REGISTRAR'S SIGNATURE <u>Loether M. Allison</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Clark</u>		ADDRESS <u>Clark Funeral Home St. Joseph, Mo.</u>	

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING 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.....
E. A. Clark

Licensed Embalmer No. *723*

P. O. Address *St. Louis, Mo.*

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.