

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **40936**
5519

94870-55
FILED JAN 11 1956

BIRTH NO. **0** REG. DIST. NO. **149** PRIMARY REG. DIST. NO. **1002** Registrar's No. **1001**

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MO b. COUNTY Jackson	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Wasson city		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Independence MO	
c. LENGTH OF STAY (in this place) Life		d. STREET ADDRESS (If rural, give location) 1213 E Walnut	
d. FULL NAME OF HOSPITAL OR INSTITUTION North East Osteopathic			

3. NAME OF DECEASED (Type or Print) a. (First) Delma b. (Middle) Lynn c. (Last) True			4. DATE OF DEATH (Month) (Day) (Year) 12 15 55		
5. SEX Female	6. COLOR OR RACE wh	7. MARRIED/NEVER MARRIED, WIDOWED, DIVORCED (Specify) never married	8. DATE OF BIRTH 12-12-55		9. AGE (In years last birthday) 3
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) infant		10b. KIND OF BUSINESS OR INDUSTRY -	11. BIRTHPLACE (City and State or Foreign Country) K.C. MO		12. CITIZEN OF WHAT COUNTRY? U.S.

13a. FATHER'S NAME Thomas O. True		13b. MOTHER'S MAIDEN NAME Rita Jane Rardon		14. NAME OF HUSBAND OR WIFE none	
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 Thos O. True ADDRESS Independence MO	

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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) atelectasis		INTERVAL BETWEEN ONSET AND DEATH 12 hrs 7620
		ANTECEDENT CAUSES Norbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Intra-uterine anoxemia DUE TO (c) Anemia		
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		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 **12-12-55**, to **12-15-55**, that I last saw the deceased alive on **12-14-55**, 1955, and that death occurred at **1:15 A.M.**, from the causes and on the date stated above.

23a. SIGNATURE C. M. Cernach (Degree or title) D.O.		23b. ADDRESS 11333 E 23rd, Indep. MO		23c. DATE SIGNED 12-15-55	
24a. BURIAL CREMATION (Specify) Burial		24b. DATE 12-14-55		24c. NAME OF CEMETERY OR CREMATORY Pravine Ridge	
24d. LOCATION (City, town, or county) Rockford Twp Caldwell MO		24e. (State) MO		25. FUNERAL DIRECTOR'S SIGNATURE Alsopugh & Cowley ADDRESS Polo MO	
DATE REC'D BY LOCAL REG. 12-19-55		REGISTRAR'S SIGNATURE Neva Minshall			

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
Student Embalmer

Signed _____

Licensed Embalmer No. _____

P. O. Address _____

Note: The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his **OWN HANDWRITING**. (Failure to complete the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.