

FILED JUN 11 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **15599**BIRTH NO. _____ REG. DIST. NO. **42** PRIMARY REG. DIST. NO. **1000** Registrar's No. **603**

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) OR TOWN St. Joseph,		c. LENGTH OF STAY (In this place) 1 yr		c. CITY OR TOWN St. Joseph		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 St. Josephs Hospital				STREET ADDRESS (If rural, give location) RT #8 0110				
3. NAME OF DECEASED (Type or Print) a. (First) Valerie b. (Middle) Gay c. (Last) Decker			4. DATE OF DEATH (Month) (Day) (Year) May 30 1956					
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH May 21, 1955		9. AGE (In years last birthday) 1	IF UNDER 1 YEAR Months 0 Days 9	IF UNDER 2 HRS. Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (City and State or Foreign Country) St. Joseph, Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13a. FATHER'S NAME Leonard Decker			13b. MOTHER'S MAIDEN NAME Mary Elsie Taylor		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 ADDRESS Leonard Decker Rt#8, St. Joseph, 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				INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)				Brain Abscess				10 days
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.				DUE TO (b) Otitis Media				15 days
				DUE TO (c) Measles				20 days
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 checked="" type="checkbox"/> NO <input 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) (Min.)		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 MAY 25, 1956 , to MAY 30, 1956 , that I last saw the deceased alive on MAY 29, 1956 , and that death occurred at 8:45 p.m. , from the causes and on the date stated above.								
23a. SIGNATURE <i>James H. Decker</i> (Degree or title) MD				23b. ADDRESS 206-7 1/2 Hwy 13 days St. Joseph, Mo		23c. DATE SIGNED 6-2-56		
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 6/2/56	24c. NAME OF CEMETERY OR CREMATORY Odd Fellows Public		24d. LOCATION (City, town, or county) (State) St. Joseph, Mo			
DATE REC'D BY LOCAL REG. June 6, 1956		REGISTRAR'S SIGNATURE <i>Eathan M. Allison</i>		FURNERAL DIRECTOR'S SIGNATURE <i>John A. Papp</i>		ADDRESS St. Joseph, Mo		

(Licensed Embalmer's Statement on Reverse Side)

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

9561 T & 1007

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 *John E. Rupp*

Licensed Embalmer No. *39*

P. O. Address *St. Joseph*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (F 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.