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0.48

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **19689**

FILED JUL 9 1956

BIRTH NO. _____ REG. DIST. NO. **42** PRIMARY REG. DIST. NO. **1000** Registrar's No. **722**

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. CITY OR TOWN St. Joseph	d. In Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (in this place) 66 Yrs.		e. STREET ADDRESS (If rural, give location) 501 South 21 Street	
d. FULL NAME OF HOSPITAL OR INSTITUTION Mo. Methodist Hospital			

3. NAME OF DECEASED (Type or Print) a. (First) Norine	b. (Middle)	c. (Last) Self	4. DATE OF DEATH (Month) (Day) (Year) June 30, 1956
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5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH July 27, 1889	9. AGE (In years last birthday) 66	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 24 HRS. Hours	IF UNDER 1 HRS. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Elevator Operator	10b. KIND OF BUSINESS OR INDUSTRY Furniture Store	11. BIRTHPLACE (City and State or Foreign Country) St. Joseph, Missouri	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Charles Hamilton	13b. MOTHER'S MAIDEN NAME Mable DeBell	14. NAME OF HUSBAND OR WIFE Newland Self
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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. 487-14-6843	17. INFORMANT'S SIGNATURE OR NAME Charles Self Sr., ADDRESS 501 So. 21 Street, St. Joseph, Mo.
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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.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Adenocarcinoma		INTERVAL BETWEEN ONSET AND DEATH 99970x 4hr
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Metastasis to entire Abdomen (Primary site undetermined) DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 1991			

19a. DATE OF OPERATION 3-12-56	19b. MAJOR FINDINGS OF OPERATION as above + leiomyomata, multiple to uterus	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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)	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 **3-13, 1955**, to **6-30, 1956**, that I last saw the deceased alive on **6-30, 1956**, and that death occurred at **6:50p m.**, from the causes and on the date stated above.

23a. SIGNATURE Wm B. Roehm (Degree or title)	23b. ADDRESS 316 No 10th St Joseph Mo	23c. DATE SIGNED 7-2-56
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE July 3, 1956	24c. NAME OF CEMETERY OR CREMATORY Mt. Mora Cemetery	24d. LOCATION (City, town, or county) (State) St. Joseph, Mo.
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DATE REC'D BY LOCAL REG. July 5, 1956	REGISTRAR'S SIGNATURE Cathleen M. Allison	25. FUNERAL DIRECTOR'S SIGNATURE Wm H. Alexander ADDRESS St. Joseph, Mo.
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(Licensed Embalmer's Statement on Reverse Side)

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

485

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..... *Wm H. Alexan*

Licensed Embalmer No. *445*

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.