

Health,
Welfare
Public
Service

300
1-56

All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes. No symptoms will be listed. All standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

FILED AUG 27 1956

THE GREAT CITY OF MISSOURI
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER
26126

Registration District No. **42** Primary Registration District No. **1000** Registrar's No. **892**

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, give TOWNSHIP only) OR TOWN St. Joseph		c. CITY OR TOWN St. Joseph	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Joseph's Hosp.		d. STREET ADDRESS 907 Mitchell Ave.	
Length of stay in 1b 25 years		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) Stella Cecelia Thrune			4. DATE OF DEATH Month Aug. Day 11 Year 1956		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 19, 1894	9. AGE (In years last birthday) 62	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Office	11. BIRTHPLACE (City and state or country) E. St. Louis, Ill.	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Higgins			14. MOTHER'S MAIDEN NAME Stella Alice Birmingham		
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. 558-34-3561	17. INFORMANT A. Walter Smith, St. Joseph, Mo		

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Antero-lateral myocardial infarction				INTERVAL BETWEEN ONSET AND DEATH 4 days	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) thrombosis of left, anterior coronary artery		4 days	
		DUE TO (c) arteriosclerotic heart disease, coronary		?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). Obesity				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. Month _____ Day _____ Year _____					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from August 7th to Aug 11th and last saw her ^{him} alive on Aug 11th 1956 . Death occurred at 1:00 AM on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE Caryl A. Potter, Jr. M.D.		22b. ADDRESS 2232 Eugene Field Ave.		22c. DATE SIGNED 8-14-56	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 8/14/56		23c. NAME OF CEMETERY OR CREMATORY High Ridge Cemetery	
24. FUNERAL DIRECTOR John Rupp		ADDRESS St. Joseph, Mo		25. DATE RECD. BY LOCAL REG. August 23, 1956	
		26. REGISTRAR'S SIGNATURE Kathleen M. Allison			

(Licensed Embalmer's Statement on Reverse Side)

REC 15 1937

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.....

Robert H. Gaylor

Licensed Embalmer No. 330

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.