

THE DEPARTMENT OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER

FILED NOV 5 - 1956

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 1154

| | | | | | |
|--|----------------------------------|---|---|---|---|
| 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 (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Joseph</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN <u>St. Joseph</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Mo. Meth. Hosp.</u> | | Length of stay in lb <u>1 week</u> | d. STREET ADDRESS <u>409 E. Colorado Ave.</u> (If outside, give location) | | Reside on Form Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) <u>LOUISE</u> First Middle Last | | | 4. DATE OF DEATH Month Day Year <u>OCT. 26 1956</u> | | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Aug. 25, 1882</u> | 9. AGE (In years last birthday) <u>74</u> | IF UNDER 1 YEAR Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u> | 11. BIRTHPLACE (City and state or country) <u>Louisville, Kentucky</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> |
| 13. FATHER'S NAME <u>Unknown</u> | | | 14. MOTHER'S MAIDEN NAME <u>Unknown</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>None</u> | 17. INFORMANT <u>Mrs. Charles Sigrist, 409 E. Colo.</u> Address <u>St. Joseph, Mo.</u> | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cerebral Hemorrhage</u> | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | | | | DUE TO (b) _____ DUE TO (c) _____ |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(n) | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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 Month, Day, Year a. m. p. m. | | | | | |
| 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 <u>2-22-54</u> to <u>10-26-56</u> and last saw her alive on <u>10-26-56</u> Death occurred at <u>1:30 p</u> m on the date stated above; and to the best of my knowledge, from the causes stated. | | | | | |
| 22a. SIGNATURE <u>Amelia Allison MD</u> (Degree or title) | | 22b. ADDRESS <u>Bootle Building</u> <u>St. Joseph, Mo.</u> | | 22c. DATE SIGNED <u>10/29/56</u> | |
| 23a. BURIAL, CREMATION, etc. (Specify) <u>Burial</u> | | 23b. DATE <u>10-29-1956</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park Cem.</u> | |
| 23d. LOCATION (City, town, or county) <u>St. Joseph, Missouri</u> (State) | | | | | |
| 24. FUNERAL DIRECTOR <u>John E. Rupp</u> ADDRESS <u>St. Joseph, Mo.</u> | | 25. DATE RECD. BY LOCAL REG. <u>Oct. 31, 1956</u> | | 26. REGISTRAR'S SIGNATURE <u>Evelyn M. Allison</u> | |

(Licensed Embalmer's Statement on Reverse Side)

Health,
Welfare
Public
Service300
1-56

All symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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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, ~~by~~, Student Embalmer No.
working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *John A. Rupp*

Licensed Embalmer No. *39*

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.