

FILED NOV 5 - 1956

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **33230**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **42** PRIMARY REG. DIST. NO. **1000** Registrar's No. **1153**

1. PLACE OF DEATH a. COUNTY <b>Buchanan</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>Buchanan</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Joseph</b>		c. CITY OR TOWN <b>St. Joseph</b>	d. 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) <b>Life</b>		e. STREET ADDRESS (If rural, give location) <b>1017 Isadore St.</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>St. Joseph's Hospital</b>			

3. NAME OF DECEASED (Type or Print)	a. (First) <b>Emma</b>	b. (Middle) <b>W</b>	c. (Last) <b>Wilmes</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>Oct. 25, 1956</b>
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5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Never Married</b>	8. DATE OF BIRTH <b>March 5, 1892</b>	9. AGE (In years last birthday) <b>64</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Dental Assistant</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Dental Office</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>St. Joseph, Mo.</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
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13a. FATHER'S NAME <b>F.C. Wilmes</b>	13b. MOTHER'S MAIDEN NAME <b>Minnie Grill</b>	14. NAME OF HUSBAND OR WIFE <b>None</b>
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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) <b>No</b>	16. SOCIAL SECURITY NO. <b>491-09-6439</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Wm G. Wilmes</b>	ADDRESS <b>St. Joseph, Mo.</b>
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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, 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) <b>Cerebral Vascular accident</b>		<b>1 hour</b>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Hypertension</b>		<b>1 1/2 yrs</b>
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"/>
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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) <b>331x</b>
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.)	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 **Nov 10**, 19**53**, to **Nov 25**, 19**56**, that I last saw the deceased alive on **Oct 25**, 19**56**, and that death occurred at **6:00p** m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <b>Crean W. Lewis M.D.</b>	23b. ADDRESS <b>520 Francis St. St. Joseph, Mo.</b>	23c. DATE SIGNED <b>10/26/56</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>10-29-56</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>	24d. LOCATION (City, town, or county) (State) <b>St. Joseph, Mo.</b>
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DATE REC'D BY LOCAL REG. <b>Oct 30, 1956</b>	REGISTRAR'S SIGNATURE <b>Ethel M. Allison</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>Herbert W. Anderson</b>	ADDRESS <b>St. Joseph, Mo.</b>
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(Licensed Embalmer's Statement on Reverse Side)

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

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

Student.....  
Signature of Student Embalmer

Signed..... 

Licensed Embalmer No..... 330

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.