

path, 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.
 USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
 Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed.

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER **3797**

FILED MAR 11 1957

Registration District No. **42** Primary Registration District No. **1000** Registrar's No. **234**

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) St. Joseph		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN St. Joseph		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) 6312 Brown St.			Length of stay in lb lifetime		d. STREET ADDRESS 6312 Brown St.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) SUSAN ^{First} ORABEL ^{Middle} NOAH ^{Last}				4. DATE OF DEATH Month March Day 2 Year 1957					
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 Oct. 24, 1887		9. AGE (In years last birthday) 69	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during normal working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (City and state or country) Hitchcock Co., Neb.,		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Zackery T. Scott				14. MOTHER'S MAIDEN NAME Flora A. Crouch					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Gus Noah, 6312 Brown St., City					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary tuberculosis Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH		
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.) 002X						
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 St. Joseph, Missouri		20g. COUNTY Buchanan		20h. STATE Missouri	
21. I attended the deceased from July 29, 1956 to Mar 2, 1957 and last saw her ^{alive} on 2/13/57 Death occurred at 10:50A m on the date stated above; and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) Martin H Christ MD				22b. ADDRESS 6106 King Hill Ave City			22c. DATE SIGNED 3/4/57		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3-4-1957	23c. NAME OF CEMETERY OR CREMATORY Odd Fellows Cemetery		23d. LOCATION (City, town, or county) (State) St. Joseph, Missouri				
24. FUNERAL DIRECTOR John Rupp ADDRESS St. Joseph, Mo.				25. DATE RECD. BY LOCAL REG. Mar 8, 1957		26. REGISTRAR'S SIGNATURE Catherine M. Allison			

MAR 19 1957

MAY 17 1957

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

Student.....
Signature of Student Embalmer

Signed *John E. Ruff*
Licensed Embalmer No. *39*

P. O. Address *St. Joseph*

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