

FILED APR 1 - 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHSTATE FILE NUMBER
7668

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 316

1. PLACE OF DEATH a. COUNTY BUCHANAN		2. USUAL RESIDENCE (Where deceased lived. BUCHANAN admission) a. STATE MISSOURI b. COUNTY HOPE	
b. CITY (If outside corporate limits, give TOWNSHIP only) Inside Limits OR TOWN St. Joseph Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN St. Joseph 01170 Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) Length of stay in 1b HOSPITAL OR INSTITUTION Mo. METH. Hosp. 4 HRS.		d. STREET ADDRESS 707 South 7th (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last FRANCES ANNA GRAHAM			4. DATE OF DEATH Month Day Year 3 22 57			
5. SEX Female	6. COLOR OR RACE CAU	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH NOV. 15, 1910	9. AGE (In years last birthday) 46	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WAITRESS		10b. KIND OF BUSINESS OR INDUSTRY RESTAURANT		11. BIRTHPLACE (City and state or country) HASTINGS, NEBR.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME JOHN P. SMITH			14. MOTHER'S MAIDEN NAME MABEL E. TRENT			
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. 486-30-0366		17. INFORMANT Address MRS. DORTHEA LIVENGOOD MOUND CITY, 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) acute pulmonary edema			INTERVAL BETWEEN ONSET AND DEATH 6-8 hrs ? ?
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) myocardial infarction		
	DUE TO (c) auricular fibrillation		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 4201			19. WAS AUTOPSY PERFORMED? 2 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 3-22-57 to 3-22-57 and last saw <u>her</u> alive on 3-22-57 Death occurred at 8 A m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Ursula W. Stearns M.D.	22b. ADDRESS Joseph Blatz St. Joseph, Mo.	22c. DATE SIGNED 3/22/57	

23a. BURIAL, CREMATION, OR OTHER DISPOSITION BURIAL	23b. DATE 3/25/57	23c. NAME OF CEMETERY OR CREMATORY Mt. Hope Cemetery	23d. LOCATION (City, town, or county) (State) MOUND City, Mo.
24. FUNERAL DIRECTOR ADDRESS James Crawford, Mound City, Mo.		25. DATE RECD. BY LOCAL REG. March 25, 1957	26. REGISTRAR'S SIGNATURE Kathleen M. Allison

(Licensed Embellisher's Statement on Reverse Side)

300
-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No 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

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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 *James H. Crawford*

Licensed Embalmer No. 479

P. O. Address *Mound City*

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