

FILED APR 8 - 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

7724

STATE FILE NUMBER

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 340

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
a. COUNTY		Buchanan		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 0117d	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		718 North 7th St.		d. STREET ADDRESS		1201 Atchison St.	
Length of stay in 1b		65 yrs		(If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH			
First		Middle		Last		Month Day Year	
FRANCES				RAU		Mar. 23 1957	
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH	
Female		White		Dec. 17, 1868		9. AGE (In years last birthday)	
						88	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country)		12. CITIZEN OF WHAT COUNTRY?	
At Home		Home		Pittsburgh, Pennsylvania		U S A	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Andrew Boeh				Theresa Myers			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address	
No		None		John Rau		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) <u>PULMONARY EDEMA</u>							
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							
DUE TO (b) <u>CARDIAC DECOMPENSATION</u>							
DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
4343							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 2							
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>3-14-53</u> to <u>3-23-57</u> and last saw her ^{alive} on <u>3-21-57</u> . Death occurred at <u>5:15A</u> m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Name or title)				22b. ADDRESS		22c. DATE SIGNED	
<u>Lawrence H. Geyer, MD</u>				<u>1302 Farson St Joseph, Mo.</u>		<u>3-25-57</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
Removal		3-26-57		Cavalry Cemetery		Wathena Kansas	
24. FUNERAL DIRECTOR ADDRESS				25. DATE RECD. BY LOCAL REG.		26. REGISTRAR'S SIGNATURE	
<u>Stamper Funeral Home St. Joseph, Mo.</u>				<u>April 1, 1957</u>		<u>Bethen M. Allison</u>	

(Licensed Embalmer's Statement on Reverse Side)

Doctor, coroner, etc. must use only 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

300
1-56Health,
Welfare
Public
Service

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 *George A. Kierke*.....

Licensed Embalmer No. *479*

P. O. Address *St. Joseph*

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.