

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED MAR 25 1957

7749

STATE FILE NUMBER
1000 Registrar's No. 285

Registration District No. 42 Primary Registration District No.

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) 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) HOSPITAL OR INSTITUTION St. Joseph's Hosp. Length of stay in lb life		d. STREET ADDRESS (If outside, give location) 2301 Clay St. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Helen Middle M. Last Thompson			4. DATE OF DEATH Month March Day 11 Year 1957		
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 13, 1888	9. AGE (In years last birthday) 68	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY own home	11. BIRTHPLACE (City and state or country) St. Joseph, Missouri	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Henry C. Girard			14. MOTHER'S MAIDEN NAME Sarah Armstrong		
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. none	17. INFORMANT George A. Thompson 2301 Clay, St. Joseph Mo.		

MEDICAL CERTIFICATION	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)				INTERVAL BETWEEN ONSET AND DEATH
	PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage				48 hours
	Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Hypertensive vascular disease				10+ years
	DUE TO (c) Right & left heart disease				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				2	
20a. ACCIDENT (SUICIDE HOMICIDE) <input type="checkbox"/> <input type="checkbox"/> <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 1-9-50 to 3-11-57 and last saw her alive on 3-11-57 Death occurred at 9:45a. m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) Lucile M. Jode M.D.			22b. ADDRESS 902 Edwards St. Joseph, Mo.	22c. DATE SIGNED 3-12-57	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE 3/13/1957	23c. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cemetery		23d. LOCATION (City, town, or county) (State) St. Joseph, Mo.
24. FUNERAL DIRECTOR Heaton-Bowman St. Joseph, Mo.		ADDRESS		25. DATE RECD. BY LOCAL REG. Mar. 18, 1957	26. REGISTRAR'S SIGNATURE Cathleen M. Allison

(Licensed Embalmer's Statement on Reverse Side)

disease 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

Health, Welfare, Public Service

300-56

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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 *William Spedding*.....
Licensed Embalmer No. 45.

P. O. Address *3195 10th St*

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.