

FILED MAY 13 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER **12173**
 Registration District No. **42** Primary Registration District No. **1000** Registrar's No. **508**
Health,  
Welfare  
Public  
Service300  
1-56

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

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, give TOWNSHIP only) OR TOWN <b>St. Joseph</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>St. Joseph</b> <b>0117</b> <b>0</b>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Mo. Methodist Hospital</b>		Length of stay in lb <b>7yrs</b>	d. STREET ADDRESS (If outside, give location) <b>102 E. Moose</b>
3. NAME OF DECEASED (Type or print) First <b>Anna</b> Middle <b>Eslinger</b> Last <b>Eslinger</b>		4. DATE OF DEATH Month <b>May</b> Day <b>7</b> Year <b>1957</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>April 4, 1887</b>
9. AGE (In years last birthday) <b>70</b>		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House keeper</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	11. BIRTHPLACE (City and state or country) <b>Marshal Co, Kansas</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Georg Wilson</b>	
14. MOTHER'S MAIDEN NAME <b>Marie ? ?</b>		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>none</b>		17. INFORMANT <b>Harison Eslinger, St. Joseph, Mo</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Cerebral Hemorrhage with left hemiplegia.</b>  Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>General Arteriosclerosis</b> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <b>Unk.</b>  <b>Unk.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(n) <b>331x</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <b>2</b>
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 _____ a. m. _____ p. m. _____ Month _____ Day _____ Year _____			
20d. INJURY OCCURRED WHILE AT <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 <b>11/9/56</b> to <b>5/7/57</b> and last saw her <del>DEAD</del> alive on <b>5/6/57</b> Death occurred at <b>8:45 A.M.</b> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>Anna Eslinger</b>		22b. ADDRESS <b>Social Welfare Board 10th &amp; Olive, Patee Hall St. Joseph, Mo.</b>	22c. DATE SIGNED <b>5/8/57</b>
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <b>5/9/57</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Odd Fellows Cemetery Public</b>	23d. LOCATION (City, town, or county) (State) <b>St. Joseph, Mo</b>
24. FUNERAL DIRECTOR <b>Paul E. Lepp</b>	ADDRESS <b>St. Joseph, Mo</b>	25. DATE RECD. BY LOCAL REG. <b>May 10, 1957</b>	26. REGISTRAR'S SIGNATURE <b>Kathleen M. Allison</b>

(Licensed Embalmer's Statement on Reverse Side)

MAY 31 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, ~~or by~~ ....., Student Embalmer No. .... working under my personal supervision..

Student.....

Signature of Student Embalmer

Signed.....

*John E. Rupp*

Licensed Embalmer No. 39

P. O. Address *St. Joseph*

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