

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED MAY 20 1957

16207

STATE FILE NUMBER

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 520

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) OR TOWN St. Joseph		c. CITY OR TOWN St. Joseph	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION 314 W. Poulin St.		d. STREET ADDRESS 314 W. (Poulin St.)	
Length of stay in 1b 21 yrs		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First IZETTA Middle CALIFORNIA Last BOYER			4. DATE OF DEATH Month May Day 10 Year 1957
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 9, 1887
9. AGE (In years last birthday) 80		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (City and state or country) San Louis, California
13. FATHER'S NAME John Odson		14. MOTHER'S MAIDEN NAME Virginia A. Smith	
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 Mr. John M. Boyer Address 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) CEREBRAL HEMORRHAGE			INTERVAL BETWEEN ONSET AND DEATH 1 HOUR
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) ESSENTIAL HYPERTENSION			UNKNOWN
DUE TO (c)			
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"/>
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.) 331X		
20c. TIME OF INJURY Hour 9:00A Month Feb Day 25 Year 1957			
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	COUNTY STATE
21. I attended the deceased from FEB 25, 1957 to MAY 10, 1957 and last saw ^{her} her alive on MAY 4, 1957 Death occurred at 9:00A m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Deceased's title) Lawrence H. Fisher MD		22b. ADDRESS 1302 Fairview St Joseph	22c. DATE SIGNED 5-11-57
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 5-13-57	23c. NAME OF CEMETERY OR CREMATORY Ashland Cemetery	23d. LOCATION (City, town, or county) (State) St. Joseph Missouri
24. FUNERAL DIRECTOR Home Funeral Home ADDRESS St. Joseph, Mo.		25. DATE RECD. BY LOCAL REG. May 14, 1957	26. REGISTRAR'S SIGNATURE Lothar W. Allison

(Licensed Embalmer's Statement on Reverse Side)

Health, Welfare Public Service

300 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 causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

350

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 *Charlie E. Bennett*

Licensed Embalmer No. *467*

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.