

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

16279

STATE FILE NUMBER

FILED MAY 20 1957

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 514

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

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 Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN St. Joseph Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Mo. Methodist Hosp.		d. STREET ADDRESS (If outside, give location) 1717 Fifth Avenue	
Length of stay in 1b 3 yrs		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First LENA Middle JANE Last STALDER			4. DATE OF DEATH Month May Day 8 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 February 24, 1895
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home		9b. AGE (In years last birthday) 62	9c. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
100. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (City and state or country) Dearborn Missouri	12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME Abner Sinkhorn		14. MOTHER'S MAIDEN NAME Lucy Tomulin	
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 John S. Stalder 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) Coronary Occlusion			INTERVAL BETWEEN ONSET AND DEATH Unk.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes			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.) 4201		
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 10/2/56 to 5/8/57 and last saw her ^{him} alive on 5/7/57 Death occurred at 2:10P m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <i>Arthur Allison MD.</i>		22b. ADDRESS Social Welfare Board 10th & Olive, Patee Hall St. Joseph, Mo.	22c. DATE SIGNED 5/9/57
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 5-10-57	23c. NAME OF CEMETERY OR CREMATORY Dearborn Cemetery	23d. LOCATION (City, town, or county) (State) Dearborn Missouri
24. FUNERAL DIRECTOR <i>St. Joseph, Mo.</i> ADDRESS _____		25. DATE RECD. BY LOCAL REG. May 14, 1957	26. REGISTRAR'S SIGNATURE <i>Cathie M. Allison</i>

(Licensed Embalmer's Statement on Reverse Side)

MAY 21 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 *George R. Kerbel*

Licensed Embalmer No. *475*

P. O. Address *Phila*

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.