

FILED JUN 17 1957

STANDARD CERTIFICATE OF DEATH

42

STATE FILE NUMBER

1000

20081

650

Registration District No. Primary Registration District No. Registrar's No.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                        |                                                                                                                                                          |                               |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY Buchanan                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                        | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE Missouri b. COUNTY Buchanan                            |                               |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN St. Joseph                                                                                                                                                                                                                                                                                                                                                                                                                     |                        | c. CITY OR TOWN St. Joseph                                                                                                                               |                               |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION 619 N. 9th St.                                                                                                                                                                                                                                                                                                                                                                                                       |                        | d. STREET ADDRESS (If outside, give location)<br>619 N. 9th St.                                                                                          |                               |
| 3. NAME OF DECEASED (Type or print)<br>First AMANDA Middle BELL Last ALFREY                                                                                                                                                                                                                                                                                                                                                                                                                         |                        | 4. DATE OF DEATH June 10, 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 May 22, 1873 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>practical nurse                                                                                                                                                                                                                                                                                                                                                                                      |                        | 11. BIRTHPLACE (City and state or country)<br>LaBelle, Mo.                                                                                               |                               |
| 13. FATHER'S NAME<br>William M. Robinson                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                        | 14. MOTHER'S MAIDEN NAME<br>Demarius Hinson                                                                                                              |                               |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br>no                                                                                                                                                                                                                                                                                                                                                                                     |                        | 17. INFORMANT Address<br>Mrs. Calista Hockabaut, 619 N. 9th St. St. Joseph                                                                               |                               |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Hypostatic Pneumonia<br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Congestive Heart Failure<br>DUE TO (c) Arteriosclerotic Cardiovascular disease<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(n)<br>Kyphoscoliosis |                        | INTERVAL BETWEEN ONSET AND DEATH<br>1 week<br>3 mo<br>years                                                                                              |                               |
| 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<br>Hour 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 3-8-57 to 6-10-57 and last saw her alive on 6-8-57                                                                                                                                                                                                                                                                                                                                                                                                                 |                        | 22. SIGNATURE (Degree or title)<br>Richard L. Maguin M.D.                                                                                                |                               |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>removal                                                                                                                                                                                                                                                                                                                                                                                                                                                |                        | 23b. DATE<br>6/10/1957                                                                                                                                   |                               |
| 23c. NAME OF CEMETERY OR CREMATORY<br>Heaton-Bowman Funeral Home, St. Joseph, Mo.                                                                                                                                                                                                                                                                                                                                                                                                                   |                        | 23d. LOCATION (City, town, or county)<br>Hiawatha, Kansas                                                                                                |                               |
| 24. FUNERAL DIRECTOR<br>Heaton-Bowman Funeral Home, St. Joseph, Mo.                                                                                                                                                                                                                                                                                                                                                                                                                                 |                        | 25. DATE RECD. BY LOCAL REG.<br>June 12, 1957                                                                                                            |                               |
| 26. REGISTRAR'S SIGNATURE<br>Richard M. Allison                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                        | 27. DATE SIGNED<br>6-11-57                                                                                                                               |                               |

(Licensed Embalmer's Statement on Reverse Side)

1957-58-59-60-61-62-63-64-65-66-67-68-69-70-71-72-73-74-75-76-77-78-79-80-81-82-83-84-85-86-87-88-89-90-91-92-93-94-95-96-97-98-99-00

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

SEP 19 1951

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 *Billie C. Gonder*.....

Licensed Embalmer No. *49*

P. O. Address *St Joseph*.....

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.