

Health, Welfare, Public Service

000
-57

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

FILED JUL 29 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

23608

STATE FILE NUMBER

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 820

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 Missouri MCH Hospital		Length of stay in lb 12 Hours	d. STREET ADDRESS (If outside, give location) 2311 Edmond Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last MARY Herndon			4. DATE OF DEATH Month Day Year 7-23-1957
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 3-4-1876
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY -	9. AGE (In years last birthday) 85
11a. FATHER'S NAME James A. Esiminger		11b. MOTHER'S MAIDEN NAME Unknown	11c. BIRTHPLACE (City and state or country) Andrew Como
12a. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		12b. SOCIAL SECURITY NO. no	12c. INFORMANT Ray Herndon
13a. FATHER'S NAME James A. Esiminger		13b. MOTHER'S MAIDEN NAME Unknown	13c. NAME OF HUSBAND OR WIFE William Herndon
14. 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 24 hours	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) hypertension		15. IF UNDER 1 YEAR Months Days Hours Min. 15 years	
DUE TO (c) arteriosclerosis, generaliz.		16. IF UNDER 24 HRS. 16 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 331X			17. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
18. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		19. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20. TIME OF INJURY Hour Month, Day, Year a.m. p.m. 9:15 a.m. 7/23/57		21. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) SAVANNAH MO	
22. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		23. CITY, TOWN, OR LOCATION .COUNTY .STATE SAVANNAH MO	
24. I attended the deceased from: 7/10/57 to 7/23/57 and last saw her alive on 7/23/57 Death occurred at 1:30 p.m. 7/23/57 m on the date stated above; and to the best of my knowledge, from the causes stated.		25. SIGNATURE (Degree or title) John C. Tompkins M.D.	
26. SIGNATURE (Degree or title) John C. Tompkins M.D.		27. ADDRESS 450 N. 8th St. St. Joseph, Mo.	
28. DATE SIGNED 7/20/57		29. BIRTHPLACE (City and state or country) Andrew Como	
30. BURIAL, CREMATION, REMOVAL (Specify) Removal		31. DATE 7-23-57	
32. NAME OF CEMETERY OR CREMATORY SAVANNAH		33. LOCATION (City, town, or county) (State) SAVANNAH MO	
34. FUNERAL DIRECTOR Preit Funeral Home Savannah		35. ADDRESS Savannah Mo	
36. DATE RECD. BY LOCAL REG. July 25, 1957		37. REGISTRAR'S SIGNATURE Mrs. Robert Fulton	

(Licensed Embalmer's Statement on Reverse Side)

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 *E. E. Breit*

Licensed Embalmer No. *2650*
P. O. Address *Savannah*

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.