

Health,
Welfare
Public
Service

FILED JUL 31 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

22611
REGISTRATION DISTRICT NO. 42 PRIMARY REGISTRATION DISTRICT NO. 1000 REGISTRAR'S NO. 793

100
-57

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Buchanan</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. Joseph</u>		c. CITY OR TOWN <u>ST. Joseph</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Jackson Nursing H.</u>		d. STREET ADDRESS <u>209 West Iowa</u>	
3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>Mae</u> Last <u>Hoye</u>		4. DATE OF DEATH Month <u>July</u> Day <u>18</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 17, 1874</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	9. AGE (In years last birthday) <u>76</u>
13a. FATHER'S NAME <u>Benjamin Bagby</u>		13b. MOTHER'S MAIDEN NAME <u>Judy Stipny</u>	11. BIRTHPLACE (City and state or country) <u>St. Joseph, Missouri</u>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>none</u>		16. SOCIAL SECURITY NO. <u>none</u>	12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u>		14. NAME OF HUSBAND OR WIFE <u>Lee Hoye</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Arteriosclerosis</u>		17. INFORMANT Address <u>Virginia Carr 670 Clinton St</u>	
DUE TO (c) _____		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) or PART II of item 18.) <u>331X</u>			
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 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 <u>7/16/57</u> to <u>7/18/57</u> and last saw <u>her</u> alive on <u>7/17/57</u> Death occurred at <u>7-18-57 3-15 PM</u> on the date stated above; and to the best of my knowledge, from the causes stated.		22a. SIGNATURE <u>S. E. Meloney, M.D.</u> (Degree or title)	
22b. ADDRESS <u>Social Welfare Board 10th & Olive, Patee Hall St. Joseph, Mo.</u>		22c. DATE SIGNED <u>7/19/57</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>7/20/57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Ashland Cemetery</u>	23d. LOCATION (City, town, or county) <u>St. Joseph Mo.</u> (State)
24. FUNERAL DIRECTOR <u>Beatrice Gray</u>	ADDRESS <u>812 Pacific</u>	25. DATE RECD. BY LOCAL REG. <u>July 23, 1957</u>	26. REGISTRAR'S SIGNATURE <u>Mrs Robert Fulton</u>

(Licensed Embalmer's Statement on Reverse Side)

JUL 31 1957

AUG 23 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 T. Miles*

Licensed Embalmer No. *3446*
P. O. Address *Catonsville*

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.