Health, Welfare Public Service

FILED JUL 22 1957

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

23637

STATE FILE NUMBER

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 781

1. PLACE OF DEATH a. COUNTY: Buchanan	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Mo b. COUNTY: Buchanan
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only): St. Joseph — Inside Limits: Yes [X] No [ ]	c. CITY OR TOWN: St. Joseph — Inside Limits: Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): Mo. Methodist Hosp — Length of stay in 1b: 50yrs	d. STREET ADDRESS (If outside, give location): 2002 So 18th — Reside on Farm: Yes [ ] No [X]

3. NAME OF DECEASED (Type or print) First: Effie Middle: Last: Nell		4. DATE OF DEATH Month Day Year: July 14, 1957	
5. SEX: Female	6. COLOR OR RACE: White	7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]	8. DATE OF BIRTH: July 15, 1871
9. AGE (In years last birthday): 85	IF UNDER 1 YEAR: Months Days	IF UNDER 24 HRS.: Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House keeper	10b. KIND OF BUSINESS OR INDUSTRY: Home	11. BIRTHPLACE (City and state or country): Indiana	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME: Unk.	13b. MOTHER'S MAIDEN NAME: Unk.	14. NAME OF HUSBAND OR WIFE: None	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.: none	17. INFORMANT: William Nell Address: St. Joseph, Mo	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Acute Cerebral Hemorrhage	1 day
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)	Cardial Vascular Renal Disease	Unk.
DUE TO (c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): 442x

19. WAS AUTOPSY PERFORMED? YES [ ] NO [ ]

20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]

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 [ ] NOT WHILE AT WORK [ ]

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 7/13/57, to 7/14/57 and last saw her alive on 7/13/57

Death occurred at 11:00 P.M. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Arvin W Dlearg MD	22b. ADDRESS: Social Welfare Board 10th & Olive, Patee Hall St. Joseph, Mo.	22c. DATE SIGNED: 7/15/57
23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: 7-17-1957	23c. NAME OF CEMETERY OR CREMATORY: Ashland Cemetery
23d. LOCATION (City, town, or county) (State): St. Joseph, Missouri		
24. FUNERAL DIRECTOR: John E. Kepp	ADDRESS: St. Joseph, Mo.	25. DATE RECD. BY LOCAL REG.: July 19, 1957
26. REGISTRAR'S SIGNATURE: Mrs. Robert Fulton		

(Licensed Embalmer's Statement on Reverse Side)

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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, ~~only~~ ....., Student Embalmer No. ..... working under my personal supervision.

Student .....
Signature of Student Embalmer

Signed .....

Licensed Embalmer No. 3986

P. O. Address .....

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.