

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

23656

STATE FILE NUMBER

FILED AUG 5 1957

Registration District No. 42

Primary Registration District No. 1000

Registrar's No. 824

300
-57
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1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before a. STATE Missouri b. COUNTY Buchanan	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph		c. CITY OR TOWN St. Joseph	
c. FULL NAME OF (If NOT in hospital or institution) HOSPITAL OR INSTITUTION Parkview-Sunnyslope Nursing Home		d. STREET ADDRESS (If outside, give location) 2707 Rennick	
3. NAME OF DECEASED (Type or print) First Middle Last JOSEPHINE SAUNDERS		4. DATE OF DEATH Month Day Year July 18, 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 15, 1873
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk (retired)		10b. KIND OF BUSINESS OR INDUSTRY Dry goods store	9. AGE (In years last birthday) 83 FUNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
13a. FATHER'S NAME Robert Perry Saunders		13b. MOTHER'S MAIDEN NAME Mary VanArsdale	14. NAME OF HUSBAND OR WIFE none
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 Address Mrs. Lawrence Jesse 108 Pawnee St.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE DUE TO (b) CARDIAC DECOMPENSATION Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH (but not related to the terminal disease condition given in PART I (a)) SUBCAPITAL FX RT. FEMUR. 4343F			INTERVAL BETWEEN ONSET AND DEATH 48 HRS. 1 WK.
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 Month, Day, Year a.m. p.m.		20d. INJURY OCCURRED WHILE AT <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 July 1956 to July 18-1957 and last saw her alive on July 18-1957 Death occurred at 8:30 p m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE John T. Rogers M.D.		22b. ADDRESS 307 Kirkpatrick St. Joseph Mo	22c. DATE SIGNED 7/20/57
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE July 22, 57	23c. NAME OF CEMETERY OR CREMATORY Mt. Washington Cem.	23d. LOCATION (City, town, or county) (State) Kansas City, Mo.
24. FUNERAL DIRECTOR Clark Funeral Home		25. DATE RECD. BY LOCAL REG. St. Joseph, Mo. July 29, 1957	26. REGISTRAR'S SIGNATURE Mrs. Robert Fulton

MEDICAL CERTIFICATION
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
All diseases in Part I must be causally related.

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 *Emmanuel Clark*

Licensed Embalmer No. *4238*

P. O. Address *St. Joseph*

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.