

alt; welfare office advice  
00  
57  
0  
MEDICAL CERTIFICATION  
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
All diseases in Part I must be causally related.

FILED SEP 9 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

57 0 275 18  
STATE FILE NUMBER

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 953

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) TOWN St. Joseph		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Joseph
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Mo. Methodist Hosp.		Length of stay in lb Lifetime	d. STREET ADDRESS (If outside, give location) Silvey Nursing Home
3. NAME OF DECEASED (Type or print) First Emma Middle Nelson Last Buffington			4. DATE OF DEATH Month Aug. Day 29, Year 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 December 8, 1876
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		9b. KIND OF BUSINESS OR INDUSTRY Own Home	9. AGE (In years last birthday) 80
10a. FATHER'S NAME Peter Nelson		10b. MOTHER'S MAIDEN NAME Charlotte Burgerson	10c. NAME OF HUSBAND OR WIFE Charles Buffington
11. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		12. SOCIAL SECURITY NO. None	12. INFORMANT Address Ida Wright, Phoebus, Virginia
13. 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  Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Cerebral Thrombosis DUE TO (c) PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			13. INTERVAL BETWEEN ONSET AND DEATH Unk.  Unk.
14a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		14b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) 331x	
15a. TIME OF INJURY Hour Month, Day, Year a.m. p.m.		15b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
16a. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		16b. CITY, TOWN, OR LOCATION COUNTY STATE	
17. I attended the deceased from 9/28/54 to 8/29/57 and last saw her alive on 8/28/57 Death occurred at 1:55 a. m. on the date stated above; and to the best of my knowledge, from the causes stated.			
18a. SIGNATURE <i>Anna W. Fleeman</i>		18b. ADDRESS Social Welfare Board 10th & Olive, Patee Hall St. Joseph, Missouri	
19a. BURIAL, CREMATION, REMOVAL (Specify) Burial		19b. DATE Aug. 31, 1957	
20a. NAME OF CEMETERY OR CREMATORY Mt. Mora Cemetery		20b. LOCATION (City, town, or county) (State) St. Joseph, Mo.	
21. FUNERAL DIRECTOR Meierhoffer-Fleeman Inc., St. Joseph, Mo.		21. DATE RECD. BY LOCAL REG. Sept. 6, 1957	
22. REGISTRAR'S SIGNATURE <i>Mrs. Robert Fulton</i>			

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  .....

Licensed Embalmer No. 4679 .....

P. O. Address St. Joseph, Mo. ....

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.