

FILED NOV 18 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

39238

STATE FILE NUMBER

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 1204

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>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>St. Joseph</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>611 No. 11th St.</u>			Length of stay in lb <u>23 years</u>		d. STREET ADDRESS <u>1020 No. 9th St.</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Grace</u> Middle <u>M.</u> Last <u>Clark</u>				4. DATE OF DEATH Month <u>Oct.</u> Day <u>29</u> Year <u>1957</u>					
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</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>Dec. 18, 1878</u>		9. AGE (In years last birthday) <u>78</u>	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) <u>housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>home</u>		11. BIRTHPLACE (City and state or country) <u>Abilene Kansas</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>John F. Freeman</u>				14. MOTHER'S MAIDEN NAME <u>Amanda Face</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No.</u>			16. SOCIAL SECURITY NO. <u>487-09-1080</u>		17. INFORMANT Address <u>Mrs. Alice Goodman 1614 Beattie City</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>Cerebro vascular accident-Haemorrhage</u>							INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			DUE TO (b) <u>Hypertensive Arteriosclerotic cardio vascular disease.</u>						
			DUE TO (c)					?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <u>2</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 _____ Month _____ Day _____ Year _____ a. m. _____ p. m. _____									
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>12-19-47</u> to <u>10-29-57</u> and last saw her alive on <u>10-28-57</u> . Death occurred at <u>8:10 A.M.</u> on the date stated above; and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <u>Wm B. Fulton</u> (Degree or title)				22b. ADDRESS <u>316 No. 10th St. Joseph, Mo.</u>			22c. DATE SIGNED <u>10-31-57</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <u>Oct. 31, 1957</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Oakhill Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Atchison Kansas</u>			
24. FUNERAL DIRECTOR <u>John E. Rupp</u> ADDRESS <u>St. Joseph</u>				25. DATE RECD. BY LOCAL REG. <u>Nov. 6, 1957</u>		26. REGISTRAR'S SIGNATURE <u>Mrs. Robert Fulton</u>			

Health,
& Welfare
S. Public
th ServiceS. 300
v. 1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Secretary of Health Department - Missouri - Specific manner required by I.S. 3.0. MO. S. 300. 1949.

(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 *John E. Rupp*
Licensed Embalmer No. *390*
Joseph
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.