

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-013304

STATE FILE NUMBER

FILED MAY 5 1958

Registration District No. 42

Primary Registration District No. 1000

Registrar's No. 446

300  
-57

1. PLACE OF DEATH a. COUNTY <b>Buchanan</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Buchanan</b>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Joseph</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>St. Joseph</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location), HOSPITAL OR INSTITUTION <b>Hill Top Nursing Home 718 No. 7th St.</b>			Length of stay in lb		d. STREET ADDRESS (If outside, give location) <b>1323 No. 13th St.</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>STELLA</b> Middle <b>JANE</b> Last <b>FREDERICKS</b>				4. DATE OF DEATH Month <b>April</b> Day <b>24</b> Year <b>1958</b>					
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov. 22, 1873</b>		9. AGE (In years last birthday) <b>84</b> 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) <b>At Home</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (City and state or country) <b>Holt County Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>		
13a. FATHER'S NAME <b>John Taylor</b>			13b. MOTHER'S MAIDEN NAME <b>Minerva A. Lucas</b>			14. NAME OF HUSBAND OR WIFE <b>Geroge W. Frederick (Dec'd)</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Mrs. Lela Ludwig St. Joseph, Mo.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pericardial Anemia</b>							INTERVAL BETWEEN ONSET AND DEATH <b>4 yrs</b>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) <b>Arteriosclerosis</b>		DUE TO (c) <b>Malnutrition + Spinality</b>			INTERVAL BETWEEN ONSET AND DEATH <b>4 yrs</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>2900</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
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 checked="" 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 <b>1955</b> to <b>1957</b> and last saw her <b>Dec 29 57</b> alive on Death occurred at <b>2:10A</b> m on the date stated above; and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) <b>W. G. Gammage</b>				22b. ADDRESS <b>4400 St Joseph Mo</b>				22c. DATE SIGNED <b>4-25-58</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>4-26-58</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Maple Grave Cemetery</b>			23d. LOCATION (City, town, or county) (State) <b>Oregon Missouri</b>		
24. FUNERAL DIRECTOR ADDRESS <b>Homer Funeral Home St. Joseph, Mo.</b>			25. DATE RECD. BY LOCAL REG. <b>April 25, 1958</b>		26. REGISTRAR'S SIGNATURE <b>Mrs. Clark Standell</b>				

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

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 *Charles E. Bennett* .....

Licensed Embalmer No. *4677* .....

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.