Health, Welfare Public Service

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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-004529 STATE FILE NUMBER

Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 204

FILED MAR 2 1959

1. PLACE OF DEATH
a. COUNTY Buchanan
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only) St. Joseph — Inside Limits Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION D.O.A.Meth.Hosp. — Length of stay in 1b 6 yrs.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Buchanan
c. CITY OR TOWN St. Joseph — Inside Limits Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location) 812 N. 3rd. St. — Reside on Farm Yes [ ] No [X]

3. NAME OF DECEASED (Type or print): First Donna Middle Ruth Last Alexander
4. DATE OF DEATH: Month Feb. Day 21 Year 1959

5. SEX: Female
6. COLOR OR RACE: Negro
7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [X]
8. DATE OF BIRTH: Aug, 5, 1894
9. AGE (In years last birthday): 64 — 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): Maid
10b. KIND OF BUSINESS OR INDUSTRY: Hotel
11. BIRTHPLACE (City and state or country): Savannah, Mo.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME: Unknown
13b. MOTHER'S MAIDEN NAME: Emma Mae Lee
14. NAME OF HUSBAND OR WIFE: George Alexander

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. 492-40-7342
17. INFORMANT Address City: Mrs. Mae Ousley-1616 Messanie St.

MEDICAL CERTIFICATION

18. 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 — INTERVAL BETWEEN ONSET AND DEATH: 1 HOUR
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b)
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 33/X
19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

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 UNATTENDED to ____ and last saw her/him alive on ____
Death occurred at 4:55 P m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Assistant City Health Officer — 22b. ADDRESS 302 Faraon St Joseph — 22c. DATE SIGNED 2-24-59

Dr. L.H.Pifer

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related. Doctor, Coroner, etc. Must use only standard nomenclature in Item 18. No symptoms will be listed.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: Feb. 25-'59
23c. NAME OF CEMETERY OR CREMATORY: Ashland Cemetery
23d. LOCATION (City, town, or County) (State): St. Joseph, Mo.

24. FUNERAL DIRECTOR: Wm. H. Alexander — ADDRESS: St. Joseph, Mo.
25. DATE RECD. BY LOCAL REG.: Feb. 24 1959
26. REGISTRAR'S SIGNATURE: Mrs. Clark Goodell

(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 Wm. H. Alexander

Licensed Embalmer No. 4450

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.