

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-004628
STATE FILE NUMBER

LED MAR 9 1959 Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 230

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-57

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 0117</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>State Hosp. #2</u>		Length of stay in lb <u>2 yrs.</u>	d. STREET ADDRESS (If outside, give location) <u>2517 Cook Road</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Genize</u> Middle <u>Cathrine</u> Last <u>Sunderland</u>			4. DATE OF DEATH Month <u>March</u> Day <u>1</u> Year <u>1959</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 8 1882</u> 26		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	11. BIRTHPLACE (City and state or country) <u>Jasper Co. Mo.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	

13a. FATHER'S NAME <u>Severine Follmer</u>		13b. MOTHER'S MAIDEN NAME <u>Sarah E. Keller</u>		14. NAME OF HUSBAND OR WIFE <u>Andrew Sunderland</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>None</u>		17. INFORMANT <u>Ward Sunderland</u> Address <u>57 Joseph Ma</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>Bilateral Hypostatic Pneumonia</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>General Debility and Senility</u>			<u>2 yrs.</u>
DUE TO (c) <u>3rd x</u>			

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>A patient in State Hosp. since March 14-57 Senile Brain</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 2
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. _____	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
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21. I attended the deceased from Mar 1 1959 to Mar 4 1959 and last saw her ^{him} alive on Mar 1, 1959
Death occurred at 3:25 P.m. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>H F Mundy, M.D.</u>	22b. ADDRESS <u>St Joseph Mo. Mar 1-1959</u>	22c. DATE SIGNED
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>Mar 2 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Hackney Cemetery</u>	23d. LOCATION (City, town, or country) (State) <u>Jasper County, Mo.</u>
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24. FUNERAL DIRECTOR <u>Wm A. Rich, Savannah, Mo.</u>	ADDRESS	25. DATE RECD. BY LOCAL REG. <u>Mar 2, 1959</u>	26. REGISTRAR'S SIGNATURE <u>Wm. Clark Goodell</u>
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(Licensed Embalmer's Statement on Reverse Side)

All diseases in Part I must be causally related.
Dr. H. F. Mundy

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 A Rich*

Licensed Embalmer No. *4778*
P. O. Address *Savannah,*

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.