t. Health,
, & Welfare
S. Public
th Service

S. 300
v. 1-57

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-020501

STATE FILE NUMBER

FILED JUN 22 1959 Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 615

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 (If NOT in hospital, give location) 606 Garden — Length of stay in 1b 8mo

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo b. COUNTY Buchanan
c. CITY OR TOWN St. Joseph, — Inside Limits Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location) 606 Garden — Reside on Farm Yes [ ] No [X]

3. NAME OF DECEASED (Type or print) First Minnie Middle Jane Last Teeter

4. DATE OF DEATH Month Day Year June 7, 1959

5. SEX Female
6. COLOR OR RACE White
7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ] 2
8. DATE OF BIRTH March 23, 1877
9. AGE (In years last birthday) 82 — 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) House keeper
10b. KIND OF BUSINESS OR INDUSTRY Home
11. BIRTHPLACE (City and state or country) Galesburg Ill.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME Daniel Blair
13b. MOTHER'S MAIDEN NAME Martha Jane Smith
14. NAME OF HUSBAND OR WIFE none

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. none
17. INFORMANT Address Freeman Roloson St. Joseph, Mo

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) Metastatic carcinoma to Abdomen approx 2-4-59
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Adenocarcinoma to Stomach approx 9-4-58
DUE TO (c)
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 151X

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X] 2

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 6-11-54, to 6-7-59 and last saw her alive on 5-29-59
Death occurred at 7:45 P.M. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE W. B. Rost M.D. (Degree or title)
22b. ADDRESS 316 North St Joseph Mo
22c. DATE SIGNED 6-8-59

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE 6/10/59
23c. NAME OF CEMETERY OR CREMATORY Fairport Cemetery
23d. LOCATION (City, town or county) (State) Fairport Mo

24. FUNERAL DIRECTOR John E. Kipp ADDRESS St. Joseph, Mo
25. DATE RECD. BY LOCAL REG. June 15, 1959
26. REGISTRAR'S SIGNATURE Mrs. Clark Goodell

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed.
All diseases in Part I must be causally related.
Dr. William B. Rost
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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, ~~only~~ ....., Student Embalmer No. ..... working under my personal supervision.

Student .....
Signature of Student Embalmer

Signed .....

Licensed Embalmer No. 3986

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.