MISSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS SEP 28 1959

59–031523
STATE FILE NUMBER

Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 964

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DOCUMENT

BY AFFIDAVIT OF

MEDICAL CERTIFICATION

1. PLACE OF DEATH
a. COUNTY: Buchanan
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Joseph
Length of stay in 1b: Life
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: Mo. Methodist Hospital
Inside Limits: Yes ☒ No ☐

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 ☒ No ☐
d. STREET ADDRESS (If outside, give location): 617 North 17th
Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First TONI Middle LOUISE Last HERMSEN
4. DATE OF DEATH: Month September Day 21, Year 1959
5. SEX: Female
6. COLOR OR RACE: White
7. Married ☐ Never Married ☒ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 9-10-1959
9. AGE (last birthday): —
IF UNDER 1 YEAR: Months — Days 11 IF UNDER 24 HR: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (City and state or country): St. Joseph, Mo.
12. CITIZEN OF WHAT COUNTRY: USA
13a. FATHER'S NAME: Clarence Hermsen
13b. MOTHER'S MAIDEN NAME: Georgia Howard
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: Clarence Hermsen Address: 617 No. 17th City

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Septicemia — INTERVAL BETWEEN ONSET AND DEATH: 6 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Prematurity
DUE TO (c):
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)
PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐
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 9/19/59, to 9/21/59 and last saw her/him alive on 9/21/59
Death occurred at 6:49 pm on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: Charles F. Shevlin (Degree or title) MD
22b. ADDRESS: 902 Edmond St.
22c. DATE SIGNED: 9/24/59

C.F. Shevlin, M.D.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: Sept. 23, 1959
23c. NAME OF CEMETERY OR CREMATORY: Mt. Olivet Cemetery
23d. LOCATION (City, town, or county) (State): St. Joseph, Mo.

24. FUNERAL DIRECTOR: H.O. Siderfaden & Son
ADDRESS: St Joseph Mo. R.R. 4,
25. DATE RECD. BY LOCAL REG.: Sept. 23, 1959
26. REGISTRAR'S SIGNATURE: Mrs. Clark Goodell

(Licensed Embalmer's Statement on Reverse Side)

Dr Nicolin

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by m

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____
Signature of Student Embalmer

Signed Robert R Gaple

Licensed Embalmer No. 3308

P. O. Address St. Joseph, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comp 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.