MISSOURI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

-61-012652
STATE FILE NUMBER

AMENDED

Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 439

FILED MAY 8 1961

DATE AMENDED

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
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ~~St. Joseph's Hospital~~ Sisters 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) 2123 North 23rd Street
Reside on Farm Yes ☒ No ☐

3. NAME OF DECEASED (Type or print) First: Jessie Middle: Emma Last: Coldsnow
4. DATE OF DEATH Month: April Day: 25 Year: 1961
5. SEX: Female
6. COLOR OR RACE: White
7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 3-21-1881
9. AGE (last birthday): 80
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HR: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (City and state or country): Lenexa Kansas
12. CITIZEN OF WHAT COUNTRY: USA
13a. FATHER'S NAME: David Legler
13b. MOTHER'S MAIDEN NAME: Louisa Miller
14. NAME OF HUSBAND OR WIFE: Henry G.Clodsnow
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: Herbert Legler Address: Lenexa Kansas

INSTEAD OF

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebrovascular insufficiency — INTERVAL BETWEEN ONSET AND DEATH: 10 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Arteriosclerosis & cardiac failure
DUE TO (c) Arteriosclerotic heart disease — 5 years
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

MEDICAL CERTIFICATION

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

SHOULD READ

21. I attended the deceased from 4-17-61, to 4/25/61 and last saw her alive on 4-25-61
Death occurred at 3:10 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.
22a. SIGNATURE (Degree or title) Lucie W. Ide M.D.
22b. ADDRESS 902 Edmond St. Joseph, Mo.
22c. DATE SIGNED 4-27-61
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal
23b. DATE 4/25/61
23c. NAME OF CEMETERY OR CREMATORY Lenexa Cemetery
23d. LOCATION (City, town, or county) (State) Lenera Kansas
24. FUNERAL DIRECTOR John E. Rupp
ADDRESS St.Joseph,Mo.
25. DATE RECD. BY LOCAL REG. May 1, 1961
26. REGISTRAR'S SIGNATURE Mrs. Clark Goodell

ITEM NO.

BY AFFIDAVIT OF

L. W. Ide, M.D.

DOCUMENT

(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 _____ Signed John E. Rupp

Signature of Student Embalmer

Licensed Embalmer No. 3986

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.