

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-028419

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

042

1000

854

STATE FILE NUMBER

AMENDED

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

FILED SEP 5 1961

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)																			
a. COUNTY <b>Buchanan</b>		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Joseph, Missouri</b>		a. STATE <b>Missouri</b>		b. COUNTY <b>Buchanan</b>																	
Length of stay in 1b <b>30 Years</b>		c. CITY OR TOWN <b>St. Joseph, Missouri</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>1002 South 10th Street</b>																	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Missouri Methodist Hospital</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>																			
3. NAME OF DECEASED (Type or print)			First			Middle			Last			4. DATE OF DEATH			Month			Day			Year		
<b>BEATRICE</b>			<b>A.</b>			<b>FALKNER</b>						<b>August</b>			<b>23</b>			<b>1961</b>					
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>Sept. 19, 1906</b>		9. AGE (last birthday) <b>54</b>		IF UNDER 1 YEAR		IF UNDER 24 HR		Months		Days		Hours		Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Owner</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Blue Town Tavern</b>				11. BIRTHPLACE (City and state or country) <b>Richland Center, Wisconsin U.S.A.</b>				12. CITIZEN OF WHAT COUNTRY											
13a. FATHER'S NAME <b>E. A. Sippy</b>				13b. MOTHER'S MAIDEN NAME <b>Unknown</b>				14. NAME OF HUSBAND OR WIFE <b>William H. Falkner Sr.</b>															
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>						17. INFORMANT <b>Son</b> Address <b>Mr. William H. Falkner Jr., -1615 S. 19th St</b>																	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:												INTERVAL BETWEEN ONSET AND DEATH											
IMMEDIATE CAUSE (a) <b>Cirrhosis Biliary - Liver</b>												<b>5 mo</b>											
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)												PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		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		Month, Day, Year		a.m.		p.m.															
20d. INJURY OCCURRED WHILE AT WORK <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													
21. I attended the deceased from <b>7-31-61</b> to <b>8-28-61</b> and last saw her <sup>from</sup> alive on <b>8-22-61</b>																							
Death occurred at <b>7:25 AM</b> on the date stated above, and to the best of my knowledge, from the causes stated.																							
22a. SIGNATURE (Degree or title) <b>H. C. Senne M.D.</b>						22b. ADDRESS <b>228 N 7th St. Joseph, Mo</b>						22c. DATE SIGNED <b>8-25-61</b>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>August 25, 1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Memorial Park Cemetery</b>				23d. LOCATION (City, town, or county) (State) <b>St. Joseph, Missouri</b>															
24. FUNERAL DIRECTOR <b>Meierhoffer-Fleeman Inc., St. Joseph, Mo.</b>						25. DATE RECD. BY LOCAL REG. <b>Aug. 30, 1961</b>		26. REGISTRAR'S SIGNATURE <b>Wm. Clark Hardell</b>															

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

H.C. Senne, M.D.

NOV 7 1961

**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 Raymond H. Trov

Licensed Embalmer No. 5147

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.