

FILED MAY 20 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

16254

STATE FILE NUMBER

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 526

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>		c. CITY OR TOWN <u>St. Joseph</u> <u>2/17/2</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Joseph's Hospital</u>		d. STREET ADDRESS <u>1811 So. 10th St.,</u>	
Length of stay in lb <u>20 yrs.</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>Nora</u> Middle <u></u> Last <u>Merritt</u>			4. DATE OF DEATH Month <u>May</u> Day <u>9</u> Year <u>1957</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 16, 1870</u>	9. AGE (In years last birthday) <u>86</u>	IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	11. BIRTHPLACE (City and state or country) <u>Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Elijah Brooks</u>			14. MOTHER'S MAIDEN NAME <u>Frances Brooks</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 Address <u>Ralph Frederick, Stanberry, Missouri</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>Arterio-sclerotic heart disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Several</u> years
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) <u>Diverticulosis and empyema of the gall bladder</u>		19. WAS AUTOPSY PERFORMED? <u>2</u> 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 _____ a. m. _____ p. m.	20d. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20f. CITY, TOWN, OR LOCATION	COUNTY STATE

21. I attended the deceased from <u>4-2-57</u> to <u>5-9-57</u> and last saw <u>her</u> alive on <u>5-9-57</u> <u>9:45</u> PM Death occurred at <u>9:45</u> <u>P</u> m on the date stated above; and to the best of my knowledge, from the causes stated.		
22a. SIGNATURE <u>E. Hamler MD</u> (Degree or title)	22b. ADDRESS <u>311 Phy. &amp; Surg. Bldg. St. Joseph</u>	22c. DATE SIGNED <u>5-11-57</u>

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>May 12, 1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Clarksdale Cemetery</u>	23d. LOCATION (City, town, or county) <u>Mo.</u> (State) <u>Clarksdale, Missouri</u>
24. FUNERAL DIRECTOR ADDRESS <u>Meierhoffer-Fleeman Inc. St. Joseph, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>May 14, 1957</u>	26. REGISTRAR'S SIGNATURE <u>Kathleen M. Allison</u>

(Licensed Embalmer's Statement on Reverse Side)

300  
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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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 *Robert R. Herring*

Licensed Embalmer No...32

P. O. Address ...St. Joseph

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