No. 300
10-48

FILED MAY 23 1949

# THE DIVISION OF HEALTH OF MISSOURI
# STANDARD CERTIFICATE OF DEATH

State File No. 14898

BIRTH NO. 26 984-49 REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 1000 Registrar's No. 568

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

**1. PLACE OF DEATH**
a. COUNTY: Buchanan
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Joseph, Mo.
c. LENGTH OF STAY (In this place): 1 Day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Joseph Hospital

**2. USUAL RESIDENCE** (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY: Buchanan
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Joseph
d. STREET ADDRESS (If rural, give location): 2916 Penn Street

**3. NAME OF DECEASED** (Type or Print)
a. (First): Rosemary
b. (Middle): *
c. (Last): Gonzales

**4. DATE OF DEATH** (Month) (Day) (Year): May 17 1949

**5. SEX**: Female
**6. COLOR OR RACE**: White
**7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED** (Specify): Never Married
**8. DATE OF BIRTH**: May 16, 1949
**9. AGE** (In years last birthday): 0 — IF UNDER 1 YEAR: Months 0, Days 1 — IF UNDER 24 HRS.: 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**:
**11. BIRTHPLACE** (State or foreign country): St. Joseph, Missouri
**12. CITIZEN OF WHAT COUNTRY?**: U.S.A.

**13a. FATHER'S NAME**: John Gonzales
**13b. MOTHER'S MAIDEN NAME**: Denna Baber
**14. NAME OF HUSBAND OR WIFE**:

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unknown) (If yes, give war or dates of service): No
**16. SOCIAL SECURITY NO.**: None
**17. INFORMANT'S SIGNATURE OR NAME**: Mr John Gonzales — ADDRESS: 2916 Penn Str.

**18. CAUSE OF DEATH**
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

**MEDICAL CERTIFICATION**

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Pre-maturity — INTERVAL BETWEEN ONSET AND DEATH: 7 mo

ANTECEDENT CAUSES
*Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b): Spina Bifida
DUE TO (c): Bi Lat Club foot

II. OTHER SIGNIFICANT CONDITIONS
*Conditions contributing to the death but not related to the disease or condition causing death.*: Poly hydraminios — 751 X

**19a. DATE OF OPERATION**:
**19b. MAJOR FINDINGS OF OPERATION**:
**20. AUTOPSY?** YES [X] NO [ ]

**21a. ACCIDENT SUICIDE HOMICIDE** (Specify):
**21b. PLACE OF INJURY** (e.g., in or about home, farm, factory, street, office bldg., etc.):
**21c. (CITY, TOWN, OR TOWNSHIP)** (COUNTY) (STATE):
**21d. TIME OF INJURY** (Month) (Day) (Year) (Hour) m.
**21e. INJURY OCCURRED** WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
**21f. HOW DID INJURY OCCUR?**

22. *I hereby certify that I attended the deceased from* May 16, 1949, *to* May 17, 1949, *that I last saw the deceased alive on* May 17, 1949, *and that death occurred at* 3:55P *m., from the causes and on the date stated above.*

**23a. SIGNATURE** (Degree or title): M. E. Grimes M.D.
**23b. ADDRESS**: St Joseph Mo
**23c. DATE SIGNED**: 5-18-49

**24a. BURIAL, CREMATION, REMOVAL** (Specify): Burial
**24b. DATE**: 5/18/1949
**24c. NAME OF CEMETERY OR CREMATORY**: Memorial Park Cemetery
**24d. LOCATION** (City, town, or county) (State): St. Joseph, Mo.

**DATE REC'D BY LOCAL REG.**: May 20, 1949
**REGISTRAR'S SIGNATURE**: E. C. Jenkins 382 0
**25. FUNERAL DIRECTOR'S SIGNATURE**: Herman Wm Sidenfaden — ADDRESS: 1802 Union St

(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 .....
Student Embalmer

Signed Elmer Thomas

Licensed Embalmer No. 2640

P. O. Address St. Joseph Mo

**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 this body is not embalmed, fact should be so stated above.**