

FILED NOV 28 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **36425**

BIRTH NO. _____		REG. DIST. NO. <b>42</b>		PRIMARY REG. DIST. NO. <b>1000</b>		Registrar's No. <b>1272</b>	
1. PLACE OF DEATH a. COUNTY <b>Buchanan</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Buchanan</b>			
b. CITY (If outside corporate limits, write RURAL and give OR TOWN <b>St. Joseph</b> )				c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Joseph</b>			
c. LENGTH OF STAY (in this place) <b>40 years</b>				d. STREET ADDRESS (If rural, give location) <b>1612 Buchanan Ave.</b>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>1612 Buchanan Ave.</b>							
3. NAME OF DECEASED (Type or Print) a. (First) <b>Josephine</b>		b. (Middle) <b>Parthine</b>		c. (Last) <b>Paxton</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>November 16, 1949</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>		8. DATE OF BIRTH <b>August 11, 1868</b>	
9. AGE (In years last birthday) <b>81</b>		IF UNDER 1 YEAR Months Days		IF UNDER 2 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>At home</b>		11. BIRTHPLACE (State or foreign country) <b>Milford, Indiana.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13a. FATHER'S NAME <b>Zackrich Levsay</b>		13b. MOTHER'S MAIDEN NAME <b>Unknown</b>		14. NAME OF HUSBAND OR WIFE <b>Lonnie Paxton</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Lonnie Paxton St. Joseph, Mo</b>			
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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Cardiac Failure</b>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Fracture Hip</b> DUE TO (c) <b>Injury</b>  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH <b>89040</b> <b>45</b>	
19a. DATE OF OPERATION <b>10/25/49</b>		19b. MAJOR FINDINGS OF OPERATION <b>Fracture Neck L. Femur</b>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <b>accident</b>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office building, etc.) <b>Bus Terminal</b>		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <b>Kansas City Jackson Mo</b>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <b>10 23 49 P.m.</b>		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <b>Slipped &amp; fell</b> <b>123</b>			
22. I hereby certify that I attended the deceased from <b>10/23</b> , 19 <b>49</b> , to <b>11/8</b> , 19 <b>49</b> , that I last saw the deceased alive on <b>11/8</b> , 19 <b>49</b> , and that death occurred at <b>9:15 P</b> m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <b>Joseph Kulowski M.D.</b>				23b. ADDRESS <b>St. Joseph, Mo</b>		23c. DATE SIGNED <b>11/18/49</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>Nov. 19, 1949</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Memorial Park Cemetery</b>		24d. LOCATION (City, town, or county) (State) <b>St. Joseph, Missouri.</b>	
DATE REC'D BY LOCAL REG. <b>Nov. 23, 1949</b>		REGISTRAR'S SIGNATURE <b>L. B. Jenkins</b>		FUNERAL DIRECTOR'S SIGNATURE <b>Shatter Meierhoffer</b>		ADDRESS <b>1946 Chouhoun St. Joseph, Mo.</b>	

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

NOV 30 1948

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 Raymond H. Morehead

Licensed Embalmer No. 4413 Missouri

P. O. Address St. Joseph, Missouri

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.