

FILED JUN 19 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 19381

BIRTH NO. _____		REG. DIST. NO. 42		PRIMARY REG. DIST. NO. 1000		Registrar's No. 693	
1. PLACE OF DEATH a. COUNTY Buchanan				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Buchanan			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Joseph		c. LENGTH OF STAY (In this place) 1 yr 8 mo 24 day		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Joseph		0117	
d. FULL NAME OF HOSPITAL OR INSTITUTION State Hospital no 2				d. STREET ADDRESS (If rural, give location) 2611 Mary			
3. NAME OF DECEASED (Type or Print) Rose		a. (First)		b. (Middle)		c. (Last)	
4. DATE OF DEATH (Month) (Day) (Year) June 6 - 1950		5. SEX Female		6. COLOR OR RACE white		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single (1)	
8. DATE OF BIRTH April 26 - 1874		9. AGE (In years of UNDER 1 YEAR last birthday) 76		10. USUAL OCCUPATION (Give kind of work done during part of working life, even if retired) Miller		11. BIRTHPLACE (State or foreign country) St. Joseph Mo	
12. CITIZEN OF WHAT COUNTRY? U.S.		13a. FATHER'S NAME William Buechle		13b. MOTHER'S MAIDEN NAME Christine Altman		14. NAME OF HUSBAND OR WIFE None	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME William Gronway St. J. Mo. 2611 Mary			
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) Chronic myocarditis ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arterio sclerosis DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH 42 21	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
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)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Jan 2 ^d , 1950, to June 6, 1950, that I last saw the deceased alive on June 6, 1950, and that death occurred at 11:40 A.M., from the causes and on the date stated above.							
23a. SIGNATURE Forrest Thomas M.D.				23b. ADDRESS St. Joseph Mo of State Hospital no 2		23c. DATE SIGNED 6/6 - 1950	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE June 8, 1950		24c. NAME OF CEMETERY OR CREMATORY Ashland Cemetery		24d. LOCATION (City, town, or county) (State) St. Joseph, Mo.	
DATE REC'D BY LOCAL REG. June 12, 1950		REGISTRAR'S SIGNATURE E. G. Jenkins		FUNERAL DIRECTOR'S SIGNATURE Hatter Meierhoffer		ADDRESS 1046 Colburn St. St. Joseph, Mo.	

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

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 ~~*****~~.....

Student Embalmer No.****

working under my personal supervision.

Signed *Robert C. Harrington*.....

Signed.....
Student Embalmer

Licensed Embalmer No. 5258 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.