

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 19450

FILED JUN 19 1950

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 1000 Registrar's No. 699

1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo</u> b. COUNTY <u>Buchanan</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>St Joseph</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>St Joseph</u>	
c. LENGTH OF STAY (in this place) <u>19450 to 22</u>		d. STREET ADDRESS (If rural, give location) <u>214 Francis St</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>State Hospital # 2</u>			
3. NAME OF DECEASED a. (First) <u>Corinna Phelps</u> b. (Middle) _____ c. (Last) _____		4. DATE OF DEATH (Month) (Day) (Year) <u>6 8 1950</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Single</u>	8. DATE OF BIRTH <u>1-1-1890</u>
9. AGE (In years last birthday) <u>60</u>	10. MONTHS <u>6</u>	11. DAYS <u>7</u>	12. IF UNDER 14 HRS. Hours Min. <u>7</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Mo</u>	12. CITIZEN OF WHAT COUNTRY? <u>America</u>
13a. FATHER'S NAME <u>Charles Phelps</u>	13b. MOTHER'S MAIDEN NAME <u>Minnie Hauger</u>	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) <u>No</u>	16. SOCIAL SECURITY NO. <u>Nil</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Charles A Phelps</u> ADDRESS <u>214 Francis St</u>	
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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Myocarditis chronic</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Arthritis</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Mental deficient congenital</u>	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>No</u>	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 <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 <u>6-7 1950</u> , to <u>6-8 1950</u> , that I last saw the deceased alive on <u>6-7 1950</u> , and that death occurred at <u>5:00 m.</u> , from the causes and on the date stated above.			
23a. SIGNATURE (Name or title) <u>Corinna Phelps</u>		23b. ADDRESS <u>State Hospital # 2</u>	23c. DATE SIGNED <u>6-8-1950</u>
24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE <u>June 10 1950</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Oakland Cemetery St Joseph</u>	24d. LOCATION (City, town, or county) (State) <u>Mo</u>
DATE REC'D BY LOCAL REG. <u>June 13, 1950</u>	REGISTRAR'S SIGNATURE <u>H. B. Jenkins</u>	382	25. FUNERAL DIRECTOR'S SIGNATURE <u>Beatrice Gray</u> ADDRESS <u>812 Pacific St</u>

(Licensed Embalmer's Statement on Reverse Side)

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 by \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Signed \_\_\_\_\_

*Eric J. Loney*

Signed \_\_\_\_\_  
Student Embalmer

Licensed Embalmer No. \_\_\_\_\_

*4679*

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.