

FILED MAY 21 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **15685**

0117

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

BIRTH NO. _____ REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 1000 Registrar's No. 539

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) life	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Joseph		0117
d. FULL NAME OF HOSPITAL OR INSTITUTION 224 East Missouri Ave.			d. STREET ADDRESS (If rural, give location) 224 East Missouri Ave.		
3. NAME OF DECEASED (Type or Print) a. (First) Laura b. (Middle) Montague c. (Last) Pickle			4. DATE OF DEATH (Month) (Day) (Year) May 16 1951		
5. SEX Female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) single	8. DATE OF BIRTH April 14, 1883		9. AGE (In years last birthday) 68
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) freight clerk		10b. KIND OF BUSINESS OR INDUSTRY Transfer Co.	11. BIRTHPLACE (State or foreign country) St. Joseph, Missouri		12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME Abraham K. Pickle		13b. MOTHER'S MAIDEN NAME Angelia Montague		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. unknown	17. INFORMANT'S SIGNATURE OR NAME Miss. Alice M. Pickle		
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION 1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Heart Failure ANTECEDENT CAUSES Rheumatic Heart Disease with Multiple Valve Damage DUE TO (b) _____ DUE TO (c) _____ 2. OTHER SIGNIFICANT CONDITIONS Cardiac Hypertrophy Conditions contributing to the death but not related to the disease or condition causing death.			INTERVAL BETWEEN ONSET AND DEATH 10 mi ? ?
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION 414x			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 <u>2-3</u> , 19 <u>51</u> , to <u>5-16</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>5-16</u> , 19 <u>51</u> and that death occurred at <u>1:40p</u> m., from the causes and on the date stated above.					
23a. SIGNATURE Wm R. Roark			23b. ADDRESS 510 Carly Rd	23c. DATE SIGNED 5-17-51	
24a. BURIAL, CREMATION, REMOVAL (Specify) burial	24b. DATE 5/18/1951	24c. NAME OF CEMETERY OR CREMATORY Mt. Hope Cemetery	24d. LOCATION (City, town, or county) (State) St. Joseph Missouri		
DATE REC'D BY LOCAL REG. May 18, 1951	REGISTRAR'S SIGNATURE Carl C. Castle	25. FUNERAL DIRECTOR'S SIGNATURE Heaton Bowman ADDRESS Funeral Home - St. Joseph, Mo.			

APR 13 1942

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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 _____

Kenneth E. Hayes

Student Embalmer No. *428*

working under my personal supervision.

Student *Kenneth E. Hayes*
Student Embalmer

Signed *William Spalding*

Licensed Embalmer No. *4535*

P. O. Address *319 S. 11th St. Des Moines, Ia*

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.