

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **29555**

FILED SEP 17 1951

BIRTH NO. _____ REG. DIST. NO. **42** PRIMARY REG. DIST. NO. **1000** Registrar's No. **936**

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Kansas b. COUNTY Doniphan	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Joseph		c. LENGTH OF STAY (in this place) 4 months	
d. FULL NAME OF HOSPITAL OR INSTITUTION Goforth Nursing Home 2502 St. Joseph Ave.		d. STREET ADDRESS (If rural, give location) 8	

3. NAME OF DECEASED (Type or Print) a. (First) Sarah b. (Middle) Elizabeth c. (Last) Simpson	4. DATE OF DEATH (Month) (Day) (Year) 9/3/51
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, married (Specify)	8. DATE OF BIRTH 8/15/1867	9. AGE (In years less birthday) 84	IF UNDER 1 YEAR Months Days	IF UNDER 2 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (State or foreign country) Kewanee Indiana	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME John Rocars	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE John Simpson
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, state war or dates of service)	16. SOCIAL SECURITY NO. No	17. INFORMANT'S SIGNATURE OR NAME Mrs Frank Simpson	ADDRESS
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.</i>	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Abdominal Sarcoma		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) 1991		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Senile - Jan Arteriosclerosis			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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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)
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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?
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22. I hereby certify that I attended the deceased from **7-10, 1951**, to **8-27, 1951**, that I last saw the deceased alive on **8-27, 1951**, and that death occurred at **3 P.M.**, from the causes and on the date stated above.

23a. SIGNATURE W. Kieker, M.D. (Degree or title)	23b. ADDRESS Thygesburg Bldg. - St. Joseph, Mo.	23c. DATE SIGNED 9-5-51
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 9/3/51	24c. NAME OF CEMETERY OR CREMATORY Fanning Cemetery	24d. LOCATION (City, town, or county) (State) Fanning Kans
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DATE REC'D BY LOCAL REG. Sept. 10, 1951	REGISTRAR'S SIGNATURE Carl C. Casby	25. FUNERAL DIRECTOR'S SIGNATURE E. L. Kamm	ADDRESS Tracy Kans.
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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.

Student
Student Embalmer

Signed E. L. Kas

Licensed Embalmer No. 3532

P. O. Address Troy Kas

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.