

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **388**

FILED JAN 31 1953

BIRTH NO. _____ REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 1000 Registrar's No. 106

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) St. Joseph	c. LENGTH OF STAY (in this place) 14 years	c. CITY (If outside corporate limits, write RURAL and give township) St. Joseph 0117	
d. FULL NAME OF HOSPITAL OR INSTITUTION Missouri Methodist Hosp.		d. STREET ADDRESS (If rural, give location) 1014 Henry St.	

3. NAME OF DECEASED (Type or Print) a. (First) Paul	b. (Middle)	c. (Last) Street	4. DATE OF DEATH (Month) (Day) (Year) January 19, 1953
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5. SEX male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) single	8. DATE OF BIRTH April 8, 1873	9. AGE (In years last birthday) 79	# UNDER 1 YEAR Months	# UNDER 1 YEAR Days	# UNDER 1 YEAR Hours	# UNDER 1 YEAR Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ret. farm hand	10b. KIND OF BUSINESS OR INDUSTRY farm	11. BIRTHPLACE (State or foreign country) Salisbury, Missouri	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME John Street	13b. MOTHER'S MAIDEN NAME Sarah unk.	14. NAME OF HUSBAND OR WIFE none
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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. none	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. Daisy Whitlinger, Salisbury, Mo.
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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		INTERVAL BETWEEN ONSET AND DEATH Unknown
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Intestinal Obstruction		
	ANTECEDENT CAUSES Morbid conditions, if any, giving DUE TO (b) _____ rise to the above cause (a) stating the underlying cause last. DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS* Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION 5705	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) (m.)	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 8-19, 1950, to 1-19, 1953, that I last saw the deceased alive on 1-19, 1953, and that death occurred at 8:10p. m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <i>W. W. Steiner</i> M.D.	23b. ADDRESS Tootle Building St. Joseph, Missouri	23c. DATE SIGNED 1-21-53
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24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE 1/19/1953	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State) Salisbury Missouri
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DATE REC'D BY LOCAL REG. Jan 29, 1953	REGISTRAR'S SIGNATURE <i>Carl C. Casper</i>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>Heaton-Bauman Funeral Home</i> St. Joseph, Mo.
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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 James P. Hawkins

Licensed Embalmer No. 4532

P. O. Address 319 South 10th St. Jersey

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.