

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

40222

State File No. ....

FILED DEC 31 1954

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 1000 Registrar's No. 1345

1. PLACE OF DEATH a. COUNTY <b>Buchanan</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>Buchanan</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Joseph</b>	c. LENGTH OF STAY (in this place) <b>84 years</b>	c. CITY OR TOWN <b>St. Joseph</b>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Parkview at Sunnyslope</b>		f. STREET ADDRESS (If rural, give location) <b>503 S. 11th St.</b>	

3. NAME OF DECEASED (Type or Print) a. (First) <b>Emily</b> b. (Middle) <b>B.</b> c. (Last) <b>White</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>December 19, 1954</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>widowed</b>	8. DATE OF BIRTH <b>April 1, 1860</b>
9. AGE (In years last birthday) <b>94</b>		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 2 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>Blue Island, Illinois</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>

13a. FATHER'S NAME <b>John A. Blanchard</b>	13b. MOTHER'S MAIDEN NAME <b>Anna Winslow</b>	14. NAME OF HUSBAND OR WIFE <b>Henry Kirke White</b>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>	16. SOCIAL SECURITY NO. <b>none</b>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Miss Sarah White, 503 S. 11th, St. Joseph, Mo.</b>

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, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Generalized arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>15 years</b>
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.  DUE TO (b) _____  DUE TO (c) _____		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>Rx. inguinal hernia multiple decubitus ulcers</b>		<b>10 years 6 weeks</b>

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <b>none</b>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) <b>St. Joseph, Buchanan, Missouri</b>
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 7-18, 1951, to 11-20, 1954 that I last saw the deceased alive on 11-20, 1954 and that death occurred at 4:10 a. m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <b>Thompson E. Potter, M.D.</b>	23b. ADDRESS <b>731 Farnox St. St. Joseph, Mo.</b>	23c. DATE SIGNED <b>12-22-54</b>
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	24b. DATE <b>12/22/1954</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Mt. Mora Cemetery</b>
24d. LOCATION (City, town, or county) (State) <b>St. Joseph, Missouri</b>		

DATE REC'D BY LOCAL REG. <b>Dec 28, 1954</b>	REGISTRAR'S SIGNATURE <b>Kathryn M. Allison</b>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>485 Heaton-Bowman St. Joseph, Mo.</b>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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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 ....., Student Embalmer No..... working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed *James B. Hawkins*.....

Licensed Embalmer No. *453*

P. O. Address *319 So 10<sup>th</sup>*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.