S. No. 300
v. 10.48

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FILED DEC 20 1954

# THE DIVISION OF HEALTH OF MISSOURI
# STANDARD CERTIFICATE OF DEATH

State File No. 40223

BIRTH NO. _____ REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 1000 Registrar's No. 1311

**1. PLACE OF DEATH**
a. COUNTY: Buchanan
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Joseph
c. LENGTH OF STAY (In this place): life
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): D.O.A. St. Joseph's Hospital

**2. USUAL RESIDENCE** (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY: Buchanan
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Joseph 0117
d. STREET ADDRESS (If rural, give location): Geiger Apartments

**3. NAME OF DECEASED** (Type or Print)
a. (First): HAZEL
b. (Middle): FANNIE
c. (Last): WILSON

**4. DATE OF DEATH** (Month) (Day) (Year): DEC 13, 1954

**5. SEX**: Female 1

**6. COLOR OR RACE**: white

**7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED** (Specify): divorced 3

**8. DATE OF BIRTH**: July 8, 1892

**9. AGE** (In years last birthday): 62
If under 1 year: Months / Days
If under 24 hrs.: Hours / Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Nurse Aid

**10b. KIND OF BUSINESS OR INDUSTRY**: Hospital

**11. BIRTHPLACE** (City and State or Foreign Country): St. Joseph, Missouri

**12. CITIZEN OF WHAT COUNTRY?**: USA

**13a. FATHER'S NAME**: Augustus Braun

**13b. MOTHER'S MAIDEN NAME**: Catherine Furtah

**14. NAME OF HUSBAND OR WIFE**: Meril

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unknown): No
(If yes, give war or dates of service)

**16. SOCIAL SECURITY NO.**: 514-12-9886

**17. INFORMANT'S SIGNATURE OR NAME ADDRESS**: Mrs. Fred Morrison, 3017 Seneca St., City

**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) Heart failure — INTERVAL BETWEEN ONSET AND DEATH: several weeks

ANTECEDENT CAUSES
*Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) Aortic stenosis — Several yrs.
DUE TO (c) Rheumatic heart disease — Several yrs.

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**

**20. AUTOPSY?** YES ☐ NO ☒

**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) m.

**21e. INJURY OCCURRED** WHILE AT WORK ☐ NOT WHILE AT WORK ☐

**21f. HOW DID INJURY OCCUR?**

22. *I hereby certify that I attended the deceased from* July 6, 19 54, *to* Aug 2, 19 54, *that I last saw the deceased alive on* Aug 2, 1954, *and that death occurred at* 1:00P *m., from the causes and on the date stated above.*

**23a. SIGNATURE** (Degree or title): Lucile W. Ide, M.D.

**23b. ADDRESS**: 902 Edmond St., St. Joseph, Mo.

**23c. DATE SIGNED**: 12-12-54

**24a. BURIAL, CREMATION, REMOVAL** (Specify): burial

**24b. DATE**: Dec 16, 1954

**24c. NAME OF CEMETERY OR CREMATORY**: Ashland Cemetery

**24d. LOCATION** (City, town, or county) (State): St. Joseph, Missouri

**DATE REC'D BY LOCAL REG.**: Dec 16, 1954

**REGISTRAR'S SIGNATURE**: Esther M. Allison 485

**25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS**: Weaton-Bowman Funeral Home St Joseph Mo

(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.

Student .....
Student Embalmer

Signed James B. Hawkins

Licensed Embalmer No. 4531

P. O. Address 319 So 10th St Joseph 7

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.