

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

21131

State File No. ....

FILED AUG 8 - 1955

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 1000 Registrar's No. 809

1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Buchanan</u>	
b. CITY (If outside corporate limits, write RURAL and give town) <u>St. Joseph</u> c. LENGTH OF STAY (in this place) <u>0</u> <u>50</u> years		c. CITY OR TOWN <u>St. Joseph</u> 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 <u>Missouri Methodist Hospital</u>		f. STREET ADDRESS (If rural, give location) <u>712 Jules St.</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>Helen</u>	b. (Middle) <u>Margaret</u>	c. (Last) <u>Comello</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>August 1, 1955</u>
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5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>May 6, 1894</u>	9. AGE (In years last birthday) <u>61</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 4 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>saleslady</u>		10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (City and State or Foreign Country) <u>Maryville, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	

13a. FATHER'S NAME <u>James K. Young</u>	13b. MOTHER'S MAIDEN NAME <u>Rebecca J. Todd</u>	14. NAME OF HUSBAND OR WIFE <u>F. S.</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) _____	16. SOCIAL SECURITY NO. <u>486-30-4649</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Grace Hawkins</u> ADDRESS <u>712 Jules, St. Joseph, Mo.</u>
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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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>7 Mos 30 days</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Leukemia, Acute, Lymphatic</u>		
	ANTECEDENT CAUSES DUE TO (b) _____ Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (c) <u>2040</u>		
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 <input type="checkbox"/> NO <input checked="" 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) _____
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 3-11-55, 19\_\_\_\_, to 8-1-55, 19\_\_\_\_, that I last saw the deceased alive on 7-31-55, 19\_\_\_\_, and that death occurred at 1:50a. m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>McSweeney M.D.</u>	23b. ADDRESS <u>207 Pils Bldg, St. Joseph, Mo</u>	23c. DATE SIGNED <u>8-1-55</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	24b. DATE <u>8/3/1955</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>St. Joseph, Missouri</u>
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DATE REC'D BY LOCAL REG. <u>Aug. 5, 1955</u>	REGISTRAR'S SIGNATURE <u>Kathleen M. Allison</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Heaton - Bowman</u> ADDRESS <u>St. Joseph, Mo.</u>
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(Licensed Embalmer's Statement on Reverse Side)

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

5551 17 23

Mr. Penman  
706  
Proctor

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.