

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

21243

State File No. ....

FILED AUG 8 - 1955

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 1000 Registrar's No. 817

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 town) <b>St. Joseph</b>	c. LENGTH OF STAY (in this place) <b>life</b>	c. CITY OR TOWN <b>Agency</b>	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Rathburn Nursing Home</b> <b>611 N. 11th St.</b>		f. STREET ADDRESS (If rural, give location)	

3. NAME OF DECEASED (Type or Print) a. (First) <b>Ella</b>	b. (Middle) <b>Lewis</b>	c. (Last) <b>Staggs</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>Aug. 2, 1955</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>Oct. 9, 1865</b>	9. AGE (In years last birthday) <b>89</b>	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) <b>housewife</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>Buchanan County, Missouri</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
--	---	---	---

13a. FATHER'S NAME <b>Joshia Lewis</b>	13b. MOTHER'S MAIDEN NAME <b>Nancy Higgins</b>	14. NAME OF HUSBAND OR WIFE <b>Thomas J.</b>
--	--	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>	16. SOCIAL SECURITY NO. <b>none</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Dennis Staggs, Agency, Mo.</b>	ADDRESS
---	-------------------------------------	---	---------

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
	1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* <b>Multiple Cerebral Hemorrhages</b>		<b>unknown</b>
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. <b>Generalized Arteriosclerosis</b>		<b>unknown</b>
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>Woman died in a local nursing home, without being under recent medical care</b>		<b>331X</b>	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <b>medical care</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)
--	--	---

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 <sup>viewed</sup> attended the deceased from **on 8/3, 1955**, to \_\_\_\_\_, 19\_\_\_\_, that I last saw the deceased alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred at **6:15 A.M.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <b>H. F. Mundy (Coroner) M.D.</b>	23b. ADDRESS <b>St. Joseph Mo</b>	23c. DATE SIGNED <b>8/3/55</b>
--	-----------------------------------	--------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>8/4/1955</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Agency Cemetery</b>	24d. LOCATION (City, town, or county) (State) <b>Agency, Missouri</b>
---	---------------------------	---	---

DATE REC'D BY LOCAL REG. <b>Aug 5, 1955</b>	REGISTRAR'S SIGNATURE <b>Eather M. Allison</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>Wheaton - Bourner</b>	ADDRESS <b>St. Joseph, Mo.</b>
---	--	---	--------------------------------

(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.....  
Signature of Student Embalmer

Signed..... *Eugen Wood* .....

Licensed Embalmer No. *380*

P. O. Address *319 1/2 10th St*

**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.