

FILED DEC 12 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. **36017**  
1285BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **42** PRIMARY REG. DIST. NO. **1000** Registrar's No. \_\_\_\_\_

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. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Rural Tremont</b>	
c. LENGTH OF STAY (In this place) <b>4 days</b>		d. STREET ADDRESS (If rural, give location) <b>R.F.D. # 1</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Mo. Methodist Hospital</b>			

3. NAME OF DECEASED (Type or Print) a. (First) <b>Delia</b> b. (Middle) <b>Giddens</b> c. (Last) <b>Giddens</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>Dec. 2 1955</b>		
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>single</b>	8. DATE OF BIRTH <b>Aug. 21, 1886</b>	9. AGE (In years last birthday) <b>69</b>	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Work</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>House Work</b>		11. BIRTHPLACE (State or foreign country) <b>Buchanan Co. Mo.</b>	
				12. CITIZEN OF WHAT COUNTRY? <b>USA.</b>	

13a. FATHER'S NAME <b>John W. Giddens</b>		13b. MOTHER'S MAIDEN NAME <b>Sarah Briles</b>		14. NAME OF HUSBAND OR WIFE <b>Single</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>Henry Giddens</b> ADDRESS <b>Agency 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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Pulmonary Embolism</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>	
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Fracture of left hip</b>		<b>4 days</b>	
		DUE TO (c) _____			
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>9030</b>			
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION <b>20</b>		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	

21a. ACCIDENT SUICIDE HOMICIDE (Specify) <b>Accident</b>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>At home</b>		21c. CITY, TOWN, OR TOWNSHIP <b>Rural Tremont Buchanan Mo.</b> (COUNTY) <b>Buchanan</b> (STATE) <b>Mo.</b>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <b>Nov. 28 1955 9a.m.</b>		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <b>Tripped over linoleum in kitchen, fell &amp; broke lf. hip</b>	

22. I hereby certify that I attended the deceased from **11-28**, 19**55**, to **12-2**, 19**55**, that I last saw the deceased alive on **12-1**, 19**55**, and that death occurred at **11:30 P. m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <b>Arthur W. Steyer, M.D.</b>		23b. ADDRESS <b>Tootle Building St. Joseph, Missouri</b>		23c. DATE SIGNED <b>12-5-55</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>12/5/1955</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Frazier Cemetery</b>	
				24d. LOCATION (City, town, or county) (State) <b>Agency, Buchanan Co. Mo.</b>	

DATE REC'D BY LOCAL REG. <b>Dec 9, 1955</b>		REGISTRAR'S SIGNATURE <b>Kathleen M. Allison</b> <b>485</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>John H. Murray Gower, Mo.</b> ADDRESS _____	
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(Licensed Embalmer's Statement on Reverse Side)

**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 Me

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed

John H. Murray

Licensed Embalmer No.

2893

P. O. Address

Gower, Mo

**Note:** The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his **OWN HANDWRITING**. (Failure to complete the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.