

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

3732

FILED FEB 25 1957

STATE FILE NUMBER

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 164

1. PLACE OF DEATH a. COUNTY Buchanan				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Buchanan			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN St. Joseph		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital give location) HOSPITAL OR INSTITUTION Missouri Methodist Hospital				Length of stay in 68 yrs		d. STREET ADDRESS (If outside, give location) 309 Virginia St.	
3. NAME OF DECEASED (Type or print) First GRACE Middle ESTELLA Last BOLTZ				4. DATE OF DEATH Month Feb. Day 10, Year 1957			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> / DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 10, 1887		9. AGE (In years last birthday) 69	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (City and state or country) Gower, Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Silas O. Filbert				14. MOTHER'S MAIDEN NAME Lula Townsend			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none		17. INFORMANT William G. Boltz Address 309 Virginia City			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular hemorrhage						INTERVAL BETWEEN ONSET AND DEATH 2-9-57	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						DUE TO (b) Hypertension	
DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour a. m. p. m.							
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from 2/9/57 to 2/10/57 and last saw her ^{him} alive on 2/10/57 Death occurred at 9:10 A m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) Martin D Christ MD				22b. ADDRESS 6106 King Hill Ave. City		22c. DATE SIGNED 2-11-57	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Feb. 12, 57	23c. NAME OF CEMETERY OR CREMATORY Memorial Park Cem.		23d. LOCATION (City, town, or county) (State) St. Joseph, Mo.		
24. FUNERAL DIRECTOR Clark Funeral Home ADDRESS St. Joseph, Mo.				25. DATE RECD. BY LOCAL REG. Feb 18, 1957		26. REGISTRAR'S SIGNATURE Kathleen M. Allison	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

300
-56

85

Buchanan	Missouri	Buchanan	Missouri
x	St. Joseph	x	St. Joseph
x	309 Virginia St.	08 yrs	Missouri Methodist Hospital
Feb. 10, 1927	SCOTT	ARMENIA	GRACE
	March 10, 1887	x	white
U.S.A.	Goway, Missouri	Own home	Housewife
	Luis Townsend		Alisa O. Filbert
309 Virginia St.	William G. Jones	none	none

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 Paul Clark, Student Embalmer No. 5

working under my personal supervision..

Student Paul F. Clark
Signature of Student Embalmer

Signed Paul Clark

Licensed Embalmer No. 42

P. O. Address St. Joseph

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (If 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 stated above.

Clark Funeral Home St. Joseph, Mo. Feb. 12, 1927