

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

12248

FILED APR 29 1957

STATE FILE NUMBER

433

Registration District No. 42 Primary Registration District No. 5123

Registrar's No.

Health,  
& Welfare  
Public  
Service

S. 300  
y. 1-56

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.

·USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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, give TOWNSHIP only) OR TOWN <b>Agency Twsp</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN <b>Faucett</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>rural Agency</b>			Length of stay in lb <b>1 mo.</b>		d. STREET ADDRESS <b>0110 0</b> (If outside, give location)		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>L.</b> Last <b>CUNDIFF</b>				4. DATE OF DEATH <b>APRIL 10, 1957</b> Month <b>APRIL</b> Day <b>10</b> Year <b>1957</b>					
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Feb 8, 1868</b>		9. AGE (In years last birthday) <b>89</b>		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housekeeper</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>home</b>		11. BIRTHPLACE (City and state or country) <b>Fanning, Kansas</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>William Gurwell</b>				14. MOTHER'S MAIDEN NAME <b>Sarah (unknown)</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 <b>Mrs. Velva Boyd, Agency, Mo.</b> Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute cardiac decompensation</b>								INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) <b>Hypertensive heart disease</b>						unknown	
		DUE TO (c) <b>Hypertension</b>						unknown	
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"/> <b>2</b>	
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 <b>9:00 AM</b> Month <b>Aug</b> Day <b>7</b> Year <b>1956</b> 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 <b>Aug 7, 1956</b> to <b>Apr 10, 1957</b> and last saw <sup>her</sup> <del>him</del> alive on <b>Apr 10, 1957</b> Death occurred at <b>9:00 AM</b> m on the date stated above; and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <b>Sharon E. Wagoner M.D.</b> (Degree or title)				22b. ADDRESS <b>301 Illinois Ave., St. Joseph, Mo.</b>			22c. DATE SIGNED <b>4-12-57</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE <b>Apr 12, 1957</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Agency Cemetery</b>		23d. LOCATION (City, town, or county) <b>Agency, Missouri</b> (State)				
24. FUNERAL DIRECTOR <b>John E. Rupp, St. Joseph, Mo.</b> ADDRESS			25. DATE RECD. BY LOCAL REG. <b>April 24, 1957</b>		26. REGISTRAR'S SIGNATURE <b>Kathleen M. Allison</b>				

(Licensed Embalmer's Statement on Reverse Side)

485  
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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 *John E. Rupp* .....  
Licensed Embalmer No. *39* .....

P. O. Address *Joseph* .....

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.