

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

16302
STATE FILE NUMBER

FILED JUN 10 1957

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 606

1. PLACE OF DEATH a. COUNTY Buchanan				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson					
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 Independence		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Joseph's Hospital			Length of stay in 1b 30 days		d. STREET ADDRESS 2211 Hall Road		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Ora Middle Belle Last Youngblood				4. DATE OF DEATH Month May 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 December 6, 1885		9. AGE (In years last birthday) 71		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY At home		11. BIRTHPLACE (City and state or country) Grand Pass, Missouri.		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Samuel T. Hoff				14. MOTHER'S MAIDEN NAME Mahala J. Wilson					
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 Carson Funeral Home Independence, Mo.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular hemorrhage Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Arteriosclerosis + DUE TO (c) Hypertension 331X PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Asthma - Congestive failure								INTERVAL BETWEEN ONSET AND DEATH 5 days 28+ yrs 20+ yrs	
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 Month, Day, Year 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 May 1, 1957 to May 10, 1957 and last saw her alive on May 10, 1957. Death occurred at 12:50 AM on the date stated above; and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) E. L. Peterson, M.D.				22b. ADDRESS Walthers Ks				22c. DATE SIGNED 6/1/57	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE May 12, 1957.		23c. NAME OF CEMETERY OR CREMATORY Floral Hills Cemetery		23d. LOCATION (City, town, or county) (State) Kansas City, Missouri.			
24. FUNERAL DIRECTOR Geo. C. Carson Funeral Home Independence, Mo.				25. DATE RECD. BY LOCAL REG. June 5, 1957		26. REGISTRAR'S SIGNATURE Eathan M. Allison			

(Licensed Embalmer's Statement on Reverse Side)

Health, & Welfare Public Service
300 1-56
All symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.
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 causally related. Coroner cannot certify to a death due to natural causes.

MEDICAL CERTIFICATION

4267

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 *Albert C. Herring*

Licensed Embalmer No. 3258

P. O. Address St. 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.