

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

20160

STATE FILE NUMBER

FILED JUN 17 1957

42

1000

641

Registration District No. Primary Registration District No. Registrar's No.

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <b>Buchanan</b>	b. CITY (If outside corporate limits, give TOWNSHIP only) Inside Limits OR TOWN <b>St. Joseph</b> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		a. STATE <b>Missouri</b> b. COUNTY <del>Buchanan</del> <b>Caldwell</b>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>505 Virginia St.</b>		Length of stay in lb <b>3 months</b>	d. STREET ADDRESS <b>0130</b> (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH		
First <b>Mary</b> Middle <b>Elizabeth</b> Last <b>Pearce</b>			Month <b>June</b>	Day <b>7</b>	Year <b>1957</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 20, 1909</b>	9. AGE (In years last birthday) <b>47</b>	IF UNDER 1 YEAR Month <b>10</b> Day <b>18</b> Hours <b></b> Min. <b></b>
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>home</b>	11. BIRTHPLACE (City and state or country) <b>Ray County, Missouri</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	

13. FATHER'S NAME <b>James Neal</b>	14. MOTHER'S MAIDEN NAME <b>Lillie Pearl Montgomery</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>none</b>	17. INFORMANT Address <b>Lila Pawlowski, St Joseph, Mo.</b>

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>Gen. malignancy - Adeno C.A. Primery Sac. Colon</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 yr.</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		
DUE TO (b) _____ 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 <b>Nov 19 1956</b> to <b>June 7, 1957</b> and last saw her <sup>him</sup> alive on <b>6-2-57</b> Death occurred at <b>7:45</b> <b>A.</b> m. on the date stated above; and to the best of my knowledge, from the causes stated.		
22a. SIGNATURE <b>Robert N. Kieber, M.D.</b>	22b. ADDRESS <b>Kirkpatrick Bldg., City</b>	22c. DATE SIGNED <b>6-7-57</b>

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	23b. DATE <b>June 10, 1957</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Graceland Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Cameron, Missouri</b>
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24. FUNERAL DIRECTOR OR ADDRESS <b>John E. Kupp, St. Joseph, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>June 13, 1957</b>	26. REGISTRAR'S SIGNATURE <b>Cather M. Allison</b>
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Health, Welfare, Public Service  
3300 1-56  
All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes. Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All

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.....  
Licensed Embalmer No. 39

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (to comply with the above constitutes grounds for revocation of license).  
If embalmed by STUDENT, he also shall sign in his OWN handwriting.  
If this body is [redacted] embalmed, fact should be so stated above.