

Health, Welfare, Public Service

000 0-56

ALL diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes. All symptoms will be stated. All

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

20197
STATE FILE NUMBER

FILED JUN 17 1957

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 646

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) Inside Limits OR TOWN St. Joseph Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN St. Joseph 0117 0 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. Josephs Hosp.		d. STREET ADDRESS 2829 So. 19th St.	
Length of stay in 1b 25 yrs		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last GRACE YOUNGER			4. DATE OF DEATH Month Day Year June 9, 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 August 20, 1892	9. AGE (In years last birthday) 64	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) attendant		10b. KIND OF BUSINESS OR INDUSTRY State Hosp. #2	11. BIRTHPLACE (City and state or country) Detroit, Mich.	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME unknown			14. MOTHER'S MAIDEN NAME unknown		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yrs, give war or dates of service) no		16. SOCIAL SECURITY NO. 489-36-4527A	17. INFORMANT Address Earl Younger, 2829 So. 19th, St. Joseph, 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) <u>Cerebrum, Pulmonary, generalized</u>		INTERVAL BETWEEN ONSET AND DEATH 6 mo. 1 year
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Cerebrum, Rt. Base.</u>	
	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"/> 2

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 5/15/57 to 6/9/57 and last saw her alive on 6/9/57
Death occurred at 9:25 a. m. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>John R. Torrey, M.D.</u>	22b. ADDRESS <u>420 N. 8th St. St. Joseph, Mo.</u>	22c. DATE SIGNED <u>6/11/57</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE <u>6/11/1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Auburn Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>St. Joseph, Missouri</u>
24. FUNERAL DIRECTOR <u>Heaton-Bowman Funeral Home, St. Joseph, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>June 12, 1957</u>	26. REGISTRAR'S SIGNATURE <u>Kathleen M. Allison</u>	

(Licensed Embalmer's Statement on Reverse Side)

SEP 6 1951

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 *Billie C. Gordon*

Licensed Embalmer No. *490*

P. O. Address *St. Joseph*

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 a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.