

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

9-000372

STATE FILE NUMBER

FILED JAN 19 1959

Registration District No. 042

Primary Registration District No. 1000

Registrar's No. 36

300  
1-57

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>Andrew</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Joseph</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>St. Joseph</b> <i>CO 20</i> 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>Mo. Meth. Hospital</b>		Length of stay in 1b <b>Life</b>	d. STREET ADDRESS (If outside, give location) <b>Route # 2</b> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>GEORGE</b> Middle Last <b>WENDA</b>			4. DATE OF DEATH Month <b>January</b> , Day <b>9</b> , Year <b>1959</b>		
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5. SEX <b>Male</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>March, 11, 1886</b>	9. AGE (In years last birthday) <b>72 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Foreman, Binder Dept. (Ret)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Combe Printing Co.</b>	11. BIRTHPLACE (City and state or country) <b>St. Joseph, Missouri</b>	12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>
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13a. FATHER'S NAME <b>Joseph Wenda</b>		13b. MOTHER'S MAIDEN NAME <b>Caroline Gross</b>	14. NAME OF HUSBAND OR WIFE <b>Mrs. Bertha Wenda</b>
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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.	17. INFORMANT Address <b>Mrs. Bertha Wenda, Rt. #2, St. Joseph, Mo.,</b>
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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>Hodgkins disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>14 months</b> <b>15 days</b> <b>in hospital</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>malignant - paralysis throat</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) <b>201X</b>		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.)
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20c. TIME OF INJURY Hour . Month, Day, Year a.m. p.m.	20d. INJURY OCCURRED WHILE AT <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
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21. I attended the deceased from <b>August 1957</b> , to <b>1/10/59-1959</b> and last saw her/him alive on <b>1/9/59</b> Death occurred at <b>11:30 A.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE <b>B B Simmons M.D.</b> (Degree or title)	22b. ADDRESS <b>801 1/2 Franklin</b>	22c. DATE SIGNED <b>1-10-59</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>Jan. 11, 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Savannah Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Savannah Missouri</b>
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24. FUNERAL DIRECTOR <b>Stamey Funeral Home</b> (GAS)	ADDRESS <b>St. Joseph, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>Jan 10, 1959</b>	26. REGISTRAR'S SIGNATURE <b>Mrs. Clark Goodell</b>
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MEDICAL CERTIFICATION

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Dr. B. B. Simmons

All diseases in Part I must be causally related. Decoy, coroner, etc. must use only standard nomenclature in their reports. No symptoms with no related.

8961 6 2 NDF

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 *Charles E. Bennett* .....

Licensed Embalmer No. *4677* .....

P. O. Address *St. Joseph Mo* .....

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.