

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-012193  
STATE FILE NUMBER

HEALTH, Welfare, Public Service **FILED APR 28 1959** Registration District No. 4 Primary Registration District No. \_\_\_\_\_ Registrar's No. 42

1. PLACE OF DEATH a. COUNTY <u>Atchison</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Iowa</u> b. COUNTY <u>Fremont</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Buchanan Twp</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN <u>Hamburg</u> 8140 8 Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		d. STREET ADDRESS (If outside, give location) <u>201 Maine</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ROSA</u> Middle <u>LEE</u> Last <u>WARD</u>		4. DATE OF DEATH Month <u>4</u> Day <u>20</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2. DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 23-1886</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	9. AGE (In years last birthday) <u>73</u> IF UNDER 1 YEAR Months <u>2</u> Days <u>27</u> Hours <u></u> Min. <u></u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>
13a. FATHER'S NAME <u>William Morelock</u>		13b. MOTHER'S MAIDEN NAME <u>Roda Light</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>479-14-4057</u>	
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>Acute leucemia</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Carcinoma of Rt. Sub maxillary gland with metastasis generalized</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) _____		17. INFORMANT Address <u>Mrs. H.C. Swanson Hamburg, Iowa</u> 1427	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <u>2</u>		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 <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 <u>June 3 1957</u> to <u>Apr 20-59</u> and last saw her alive on <u>Apr 15, 1959</u> Death occurred at <u>20 am</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>A. R. Warramaker M.D.</u>		22b. ADDRESS <u>Hamburg Iowa</u>	
22c. DATE SIGNED <u>4/21/59</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>4-23-1959</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Mt Olive Cemetery</u>		23d. LOCATION (City, town, or county) <u>Hamburg Iowa</u>	
24. FUNERAL DIRECTOR ADDRESS <u>Oral C. Johnson Hamburg Iowa</u>		25. DATE RECD. BY LOCAL REG. <u>April 23, 1959</u>	
26. REGISTRAR'S SIGNATURE <u>Therwin N. Schaefer</u>			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

300  
1-57

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.

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 myself....., Student Embalmer No. .... working under my personal supervision.

Student .....  
Signature of Student Embalmer

Signed Carl C. Johnson.....

Licensed Embalmer No. 2839.....

P. O. Address... Hamby Ave.....

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.