THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-016794
STATE FILE NUMBER

FILED MAY 25 1959 Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 533

1. PLACE OF DEATH
a. COUNTY: Buchanan
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only): St. Joseph — Inside Limits: Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): Mo. Methodist Hosp. — Length of stay in 1b: Life

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri b. COUNTY: Buchanan
c. CITY OR TOWN: St. Joseph — Inside Limits: Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location): 1122 Powell St., — Reside on Farm: Yes [ ] No [X]

3. NAME OF DECEASED (Type or print): First: GERTRUDE Middle: MAE Last: DIETER

4. DATE OF DEATH Month: May Day: 17 Year: 1959

5. SEX: Female **6. COLOR OR RACE:** White **7. MARRIED** [X] **NEVER MARRIED** [ ] **WIDOWED** [ ] **DIVORCED** [ ]

8. DATE OF BIRTH: June 19, 1881

9. AGE (In years last birthday): 78 — IF UNDER 1 YEAR: Months: Days: — IF UNDER 24 HRS: 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: Own Home
11. BIRTHPLACE (City and state or country): St. Joseph, Missouri
12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME: unknown Hughes
13b. MOTHER'S MAIDEN NAME: Lucy unknown
14. NAME OF HUSBAND OR WIFE: George W. Dieter

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: unknown
17. INFORMANT Address: George W. Dieter, St. Joseph, Missouri

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Aleukemic leukemia — INTERVAL BETWEEN ONSET AND DEATH: 2 years.
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): 2044
19. WAS AUTOPSY PERFORMED? YES [X] NO [ ]

20a. ACCIDENT [ ] **SUICIDE** [ ] **HOMICIDE** [ ]
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. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
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 4-25-59, to 5-16-59 and last saw her/him alive on 5-16-59
Death occurred at 9:40 A.m. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Lucien W. Ide M.D.
22b. ADDRESS: 902 Edmond St. Joseph, Mo
22c. DATE SIGNED: 5-20-59

23a. BURIAL, CREMATION, REMOVAL (Specify): burial
23b. DATE: May 20, 1959
23c. NAME OF CEMETERY OR CREMATORY: Mt. Auburn Cemetery
23d. LOCATION (City, town, or county) (State): St. Joseph, Missouri

24. FUNERAL DIRECTOR: Meuschke-Hessen Inc. ADDRESS: St. Joseph, Mo.
25. DATE RECD. BY LOCAL REG.: May 22, 1959
26. REGISTRAR'S SIGNATURE: Mrs. Clark Goodell

All diseases in Part I must be causally related.
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Dr. Lucien W. Ide

MAY 28 1959

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. 4679

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.