

FILED JUN 20 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

18639

State File No.

BIRTH NO. _____ REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 1000 Registrar's No. 665

1. PLACE OF DEATH a. COUNTY <u>Buolavaan</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Joseph</u>	c. LENGTH OF STAY (in this place) <u>3 mos 19 days</u>	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kansas City</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>State Hospital No. 2.</u>		d. STREET ADDRESS (If rural, give location) <u>523 Grand Ave.</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>JAMES</u>	b. (Middle) <u>—</u>	c. (Last) <u>DOHERTY.</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>JUNE 14 1949</u>
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>10-6-1895.</u>	9. AGE (In years last birthday) <u>53</u>	IF UNDER 1 YEAR Months <u>8</u> Days <u>8</u>	IF UNDER 1 W. Wks. Hours <u>—</u> Min. <u>—</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unknown</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>unknown</u>	11. BIRTHPLACE (State or foreign country) <u>Paola, Kansas.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		

13a. FATHER'S NAME <u>unknown</u>	13b. MOTHER'S MAIDEN NAME <u>unknown</u>	14. NAME OF HUSBAND OR WIFE <u>unknown.</u>
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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) <u>no.</u>	16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT'S SIGNATURE OR NAME <u>H.A. Sargent - 523 Grand Ave. R.C. Mo.</u>	ADDRESS <u>R.C. Mo.</u>
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Atypical Pneumonia</u>		<u>4 days</u>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		<u>492X</u>
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Pericardial Abscess with pleuritic peritonitis</u>		<u>3 days</u>

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6-7-1949, to 6-13-1949, that I last saw the deceased alive on 6-13-1949, and that death occurred at 1:10 AM., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>J. H. Morrow - 1) M.D.</u>	23b. ADDRESS <u>St. Joseph, Mo. State Hospital No. 2.</u>	23c. DATE SIGNED <u>6-14-1949.</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>removed</u>	24b. DATE <u>6/15/1949</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Anatomical Board</u>	24d. LOCATION (City, town, or county) (State) <u>Kirkville Mo.</u>
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DATE REC'D BY LOCAL REG. <u>June 17, 1949</u>	REGISTRAR'S SIGNATURE <u>E. C. Jenkins</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Heaton Bowman Funeral Home</u>	ADDRESS <u>St. Joseph Mo.</u>
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(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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
Student Embalmer

Signed William Spalding

Licensed Embalmer No. 4535

P. O. Address 319 S. 10th Street

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 this body is not embalmed, fact should be so stated above.