

FILED NOV 5 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 32668

BIRTH NO. _____ REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 1000 Registrar's No. 1112

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

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, write RURAL and give town or town) St. Joseph		c. CITY (If outside corporate limits, write RURAL and give township) St. Joseph 0117	
d. FULL NAME OF HOSPITAL OR INSTITUTION Sisters Hospital		d. STREET ADDRESS (If rural, give location) 219 South 15th St.	
3. NAME OF DECEASED (Type or Print) a. (First) Patricia		b. (Middle) Lynn	
c. (Last) Mayabb		4. DATE OF DEATH (Month) (Day) (Year) October 31, 1951	
5. SEX female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) single	8. DATE OF BIRTH July 16, 1949
9. AGE (In years last birthday) 2		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	11. BIRTHPLACE (State or foreign country) Portland, Oregon
10b. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? USA	

13a. FATHER'S NAME James D. Mayabb	13b. MOTHER'S MAIDEN NAME Lois Daugherty	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME Mr. James D. Mayabb, 219 S. 15th, St. Joseph, Mo.	ADDRESS
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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, ashenia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>Acute Broncho Pneumonia</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) <i>Baby died enroute to the hospital, following attacks of vomiting and</i>		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <i>Choking.</i>		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE	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)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR
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22. I hereby certify that I *viewed* the deceased *on* 10/31, 1951, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 12:20 P. m., from the causes and on the date stated above.

23a. SIGNATURE <i>H F Mundy MD</i> (Degree or title)	23b. ADDRESS <i>St Joseph Mo</i>	23c. DATE SIGNED <i>10/1/51</i>
24a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	24b. DATE <i>11/3/1951</i>	24c. NAME OF CEMETERY OR CREMATORY <i>Memorial Park Cemetery</i>
24d. LOCATION (City, town, or county) (State) <i>St. Joseph Missouri</i>	25. FUNERAL DIRECTOR'S SIGNATURE <i>Heaton-Bauman</i>	ADDRESS <i>Funeral Home</i>
DATE REC'D BY LOCAL REG. <i>Nov. 2, 1951</i>	REGISTRAR'S SIGNATURE <i>Carl C. Casst</i>	ADDRESS <i>St. Joseph, Mo.</i>

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.....

.....
working under my personal supervision.

Student Embalmer No.....

Signed.....

James B. Hawkins

Signed.....
Student Embalmer

Licensed Embalmer No. 4536

P. O. Address 319 South 10th St. Jax

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.