

**THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH**

State File No. **7411**

FILED APR 15 1952

BIRTH NO. _____ REG. DIST. NO. **42** PRIMARY REG. DIST. NO. **1000** Registrar's No. **378**

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 township) OR TOWN St. Joseph		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Joseph 0117	
c. LENGTH OF STAY (In this place) 8 weeks		d. STREET ADDRESS (If rural, give location) 3321 Doniphan St. 0	
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Duncan Nursing Home 723 So. 11th			

3. NAME OF DECEASED (Type or Print)	a. (First) Levi	b. (Middle) Edward	c. (Last) Hughes	4. DATE OF DEATH (Month) (Day) (Year) April 8, 1952
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5. SEX male 0	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) single	8. DATE OF BIRTH March 25, 1863	9. AGE (In years last birthday) 89	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 1 YEAR Hours	IF UNDER 1 YEAR Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ret. warehouseman	10b. KIND OF BUSINESS OR INDUSTRY Grocery Co.	11. BIRTHPLACE (State or foreign country) Howe, Nebraska /	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Amos Hughes	13b. MOTHER'S MAIDEN NAME Martha Gray	14. NAME OF HUSBAND OR WIFE _____
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or date of service) _____	16. SOCIAL SECURITY NO. _____	17. INFORMANT'S SIGNATURE OR NAME Robert Grubbs, 3321 Doniphan, 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, asthenia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Fracture of Left Patella		INTERVAL BETWEEN ONSET AND DEATH 10 weeks
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Generalized Arteriosclerosis		

19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION E9000-21	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) Accident	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home	21c. (CITY, TOWN, OR TOWNSHIP) 131 (COUNTY) (STATE) St. Joseph Buchanan Missouri
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) Jan 30, 1952	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? Fell down stair in home
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22. I hereby certify that I attended the deceased from **Feb 1, 1952** to **Feb 6, 1952** that I last saw the deceased alive on **Feb 6, 1952** and that death occurred at **6:15a. m.**, from the causes and on the date stated above.

23a. SIGNATURE Wm R. McDaniel, M.D. (Degree or title)	23b. ADDRESS 902 Edmond St, St Joseph	23c. DATE SIGNED 4/9/52
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 4/10/1952	24c. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cemetery	24d. LOCATION (City, town, or county) (State) St. Joseph Missouri
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DATE REC'D BY LOCAL REG. April 11, 1952	REGISTRAR'S SIGNATURE Carl C. Casito	25. FUNERAL DIRECTOR'S SIGNATURE Heaton Bowman Funeral Home	ADDRESS St Joseph, Mo.
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(Licensed Embalmer's Statement on Reverse Side)

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

0117

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. *4635* _____

P. O. Address *3195 11th St. Wash. D.C.* _____

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.