

FILED FEB 24 1953

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 4872

BIRTH NO. _____ REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 1000 Registrar's No. 227

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Clinton	
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 Agency, Rural, 0-250	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Joseph Hospital		d. STREET ADDRESS (If rural, give location) R.F.D. # 1	

3. NAME OF DECEASED (Type or Print)	a. (First) William	b. (Middle) H.	c. (Last) Giddens	4. DATE OF DEATH (Month) (Day) (Year)	2 (14) 1953
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5. SEX male 0	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single U	8. DATE OF BIRTH 11/16/1888	9. AGE (In years last birthday) 64	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmer	10b. KIND OF BUSINESS OR INDUSTRY farming	11. BIRTHPLACE (State or foreign country) Buchanan Co. Mo. 0	12. CITIZEN OF WHAT COUNTRY U.S.A.
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13a. FATHER'S NAME John W. Giddens	13b. MOTHER'S MAIDEN NAME Sarah Briles	14. NAME OF HUSBAND OR WIFE Single
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. none	17. INFORMANT'S SIGNATURE OR NAME Henry Giddens	ADDRESS Agency, MO.
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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.	1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Congestive Heart Failure		INTERVAL BETWEEN ONSET AND DEATH Unknown
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) 4341		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Ayerza's Disease		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input 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)
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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 attended the deceased from 6-27, 1952, to 2-14, 1953, that I last saw the deceased alive on 2-13, 1953, and that death occurred at 7:00 A.M., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <i>Chen W. Sking, M.D.</i>	23b. ADDRESS Tootle Building St. Joseph, Mo.	23c. DATE SIGNED 2-17-53
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24a. BURIAL, CREMATION, REMOVAL (Specify) burial	24b. DATE 2/16/1953	24c. NAME OF CEMETERY OR CREMATORY Frazier Cemetery	24d. LOCATION (City, town, or county) (State) Agency, Mo.
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DATE REC'D BY LOCAL REG. Feb 19, 1953	REGISTRAR'S SIGNATURE <i>Carl C. Casutt</i>	25. FUNERAL DIRECTOR'S SIGNATURE <i>John H. Murray</i>	ADDRESS Lower Mo.
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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 Me

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed John H. Murray

Licensed Embalmer No. 2893

P. O. Address Gower, 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 this body is not embalmed, fact should be so stated above.