

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

35065

State File No.

BIRTH NO. _____ REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 1000 Registrar's No. 1118

1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Buchanan</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Joseph</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Joseph</u> <u>0117</u> <u>0</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Missouri Methodist Hospital</u>		d. STREET ADDRESS (If rural, give location) <u>317 N. 10th St.</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>Charles</u>	b. (Middle) <u>G.</u>	c. (Last) <u>Haller</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>October 13, 1953</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>married</u>	8. DATE OF BIRTH <u>December 28, 1873</u>	9. AGE (In years last birthday) <u>79</u>	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) <u>ret. laborer</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Buffalo, New York</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13a. FATHER'S NAME <u>unk.</u>	13b. MOTHER'S MAIDEN NAME <u>unk</u>	14. NAME OF HUSBAND OR WIFE <u>Nellie W.</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>Mrs. Nellie Haller, 317 N. 10th, St. Joseph, Mo.</u>	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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary Occlusion</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Coronary Sclerosis</u> DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

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) <u>4201</u>
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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 Oct 5, 1953 to Oct 13, 1953, that I last saw the deceased alive on Oct 13, 1953, and that death occurred at 8:25 a. m., from the causes and on the date stated above.

23a. SIGNATURE <u>D. L. Lenoir</u> (Degree or title) <u>M.D.</u>	23b. ADDRESS <u>St. Joseph, Mo.</u>	23c. DATE SIGNED <u>Oct 15 1953</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	24b. DATE <u>10/15/1953</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Ashland Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>St. Joseph, Missouri</u>
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DATE REC'D BY LOCAL REG. <u>Oct 27, 1953</u>	REGISTRAR'S SIGNATURE <u>Kathleen M. Allison</u> <u>485</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Newton-Bauman 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 St. Joplin*

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.