

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

BIRTH NO. 5-91/91-54 REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 1000 Registrar's No. 909

1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Iowa</u> b. COUNTY <u>Woodbury</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>St. Joseph</u>		c. LENGTH OF STAY (in this place) <u>4 days</u>	c. CITY OR TOWN <u>Sioux City</u>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Joseph's Hospital</u>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
e. STREET ADDRESS (If rural, give location) <u>600 Sioux St.</u>		<u>8140</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>DAVID</u> b. (Middle) _____ c. (Last) <u>HENRY</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>August 10, 1954</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Never married</u>	8. DATE OF BIRTH <u>Aug. 6, 1954</u>
9. AGE (In years last birthday) <u>4</u>		IF UNDER 1 YEAR Months _____ Days <u>4</u>	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>St. Joseph, Mo.</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			

13a. FATHER'S NAME <u>Joseph Henry</u>	13b. MOTHER'S MAIDEN NAME <u>Myrtis Smith</u>	14. NAME OF HUSBAND OR WIFE <u>None</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Myrtis Smith, Sioux City, Iowa</u> ADDRESS _____

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, asthma, 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>Prematurity 5 mos. Gestation</u>		
	ANTECEDENT CAUSES 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.			

19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION _____	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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) _____	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 Aug 6, 1954, to Aug 10, 1954, that I last saw the deceased alive on Aug 10, 1954, and that death occurred at 12:30P m., from the causes and on the date stated above.

23a. SIGNATURE <u>H. Petersen M.D.</u> (Degree or title)	23b. ADDRESS <u>St. Joseph, Mo.</u>	23c. DATE SIGNED <u>8-12-54</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>Aug 12, 1954</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Ashland Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>St. Joseph, Mo.</u>
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DATE REC'D BY LOCAL REG. <u>Aug 23, 1954</u>	REGISTRAR'S SIGNATURE <u>Kathleen M. Allison</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Stoney Funeral Home</u> ADDRESS <u>St. Joseph, Mo.</u>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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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.....  
Signature of Student Embalmer

Signed. *Charles E. Bennett*.....

Licensed Embalmer No. *467*.....

P. O. Address *St. Joseph*.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.