

32273

FILED OCT 17 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

BIRTH NO. _____		REG. DIST. NO. <u>42</u>		PRIMARY REG. DIST. NO. <u>1000</u>		Registrar's No. <u>1093</u>			
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 town or township) <u>St. Joseph</u>		c. LENGTH OF STAY (in this place) <u>2 days</u>		c. CITY OR TOWN <u>St. Joseph</u>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Joseph's Hospital</u>				e. STREET ADDRESS (If rural, give location) <u>R. R. #8</u>					
3. NAME OF DECEASED (Type or Print) a. (First) <u>DANIEL</u> b. (Middle) <u>PAUL</u> c. (Last) <u>HALTER</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Oct. 8, 1955</u>						
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>divorced</u>		8. DATE OF BIRTH <u>Sept. 17, 1917</u>			
9. AGE (In years last birthday) <u>38</u>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 2 HRS. Hours _____ Min. _____					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farmer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>farm</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Panama, Okla.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13a. FATHER'S NAME <u>J. J. Halter</u>			13b. MOTHER'S MAIDEN NAME <u>unknown</u>			14. NAME OF HUSBAND OR WIFE <u>Coleen</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>W.W. 11</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>J. J. Halter, R.R. #8, St. Joseph, Mo.</u>					
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 1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Concussion</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) <u>Man fell the distance of four stair steps, striking his head on a concrete floor.</u> 2. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>He died thirteen hours later without regaining consciousness.</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____							
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>Accident Tavern Basement</u>		21b. PLACE OF INJURY (e.g., for about home, farm, factory, street, office bldg., etc.) <u>St. Joseph, Buchanan, Mo.</u>		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>St. Joseph, Buchanan, Mo.</u>					
21d. TIME OF INJURY <u>Oct 7, 1955 9:00 P.m.</u>		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Fell off stair step to basement</u>					
22. I hereby certify that I <u>viewed</u> the deceased from <u>10/8</u> , 19 <u>55</u> , to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>10:00 A.m.</u> , from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title) <u>H. F. Mundy (Coroner) M.D.</u>				23b. ADDRESS <u>St. Joseph, Mo.</u>		23c. DATE SIGNED <u>10/8/55</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		24b. DATE <u>10/10/1955</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Agency Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Agency, Missouri</u>			
DATE REC'D BY LOCAL REG. <u>Oct 11, 1955</u>		REGISTRAR'S SIGNATURE <u>Kathleen M. Allison</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Heaton-Bowman Funeral Home, St. Joseph, Mo.</u>					

(Licensed Embalmer's Statement on Reverse Side)

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

300
48

RECEIVED

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: *William Spelling*

Licensed Embalmer No. 463

P. O. Address 3195 10th St

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.