

FILED OCT 17 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

32303

State File No.

BIRTH NO. _____ REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 1000 Registrar's No. 1086

1. PLACE OF DEATH a. COUNTY <u>Douglas</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Jay</u>					
b. CITY (If outside corporate limits, write RURAL and give township) <u>St. Joseph</u>		c. LENGTH OF STAY (In this place) <u>1 day</u>		c. CITY <u>Higginsville</u>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>State Hospital No. 2.</u>				e. STREET ADDRESS (If rural, give location) <u>0541/</u>					
3. NAME OF DECEASED (Type or Print) a. (First) <u>JOSEPH H.</u>			b. (Middle) <u>L.</u>		c. (Last) <u>MAHER</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>10-5-1955</u>		
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>		8. DATE OF BIRTH <u>Feb. 5-1871</u>		9. AGE (In years last birthday) <u>84</u> IF UNDER 1 YEAR: Months <u>8</u> Days <u>0</u> IF UNDER 24 HRS. Hours <u>0</u> 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>Agriculture</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Missouri</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13a. FATHER'S NAME <u>Patrick Maher</u>			13b. MOTHER'S MAIDEN NAME <u>McPherson</u>			14. NAME OF HUSBAND OR WIFE <u>McPherson</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Lawrence Maher Higginsville, Mo.</u>					ADDRESS
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <u>Cerebral hemorrhage</u>				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral hemorrhage</u>				INTERVAL BETWEEN ONSET AND DEATH <u>on admission</u>	
* This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.				ANTECEDENT CAUSES DUE TO (b) <u>Arterio sclerosis</u>					
				DUE TO (c) <u>331X</u>					
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"/>	
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) (Min.)		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 <u>10-5-1955</u> to <u>10-5-1955</u> , that I last saw the deceased alive on <u>10-5-1955</u> , and that death occurred at <u>5:35 P.M.</u> , from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title) <u>J. H. Maroney</u>				23b. ADDRESS <u>No. 10, State Hospital No. 2, St. Joseph, Mo.</u>			23c. DATE SIGNED <u>10-5-1955</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Remove</u>		24b. DATE <u>10/5/1955</u>		24c. NAME OF CEMETERY OR CREMATORY		24d. LOCATION (City, town, or county) (State) <u>Higginsville, Mo.</u>			
DATE REC'D BY LOCAL REG. <u>Oct 11, 1955</u>		REGISTRAR'S SIGNATURE <u>Kathleen M. Allison</u>		485		25. FUNERAL DIRECTOR'S SIGNATURE <u>Heston Brown</u>		ADDRESS <u>St. Joseph, Mo.</u>	

(Licensed Embalmer's Statement on Reverse Side)

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

0.300
0.48

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 *Richard D. Collins*.....

Licensed Embalmer No. *495*
317
P. O. Address *St. Joe*.....

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.