

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. ....

FILED APR 9 - 1956

 BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 1000 Registrar's No. 374

1. PLACE OF DEATH a. COUNTY <p align="center"><b>Buchanan</b></p>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <p align="center"><b>Missouri</b></p>		b. COUNTY <p align="center"><b>Buchanan</b></p>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <p align="center"><b>St. Joseph</b></p>		c. LENGTH OF STAY (in this place) <p align="center"><b>34 years</b></p>		c. CITY OR TOWN <p align="center"><b>St. Joseph</b></p>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <p align="center"><b>210 1/2 S. 11th St.</b></p>		e. STREET ADDRESS (If rural, give location) <p align="center"><b>210 1/2 S. 11th St.</b></p>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or Print) a. (First) <b>PHILIP</b> b. (Middle) <b>GEORGE</b> c. (Last) <b>HEWITT</b>			4. DATE OF DEATH (Month) (Day) (Year) <p align="center"><b>April 1, 1956</b></p>		
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, <u>married</u> (Specify)	
8. DATE OF BIRTH <p align="center"><b>June 26, 1881</b></p>		9. AGE (In years last birthday) <p align="center"><b>74</b></p>		10. IF UNDER 1 YEAR: Months _____ Days _____ 11. IF UNDER 2 HRS.: Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <p align="center"><b>Retired Merchant</b></p>		10b. KIND OF BUSINESS OR INDUSTRY <p align="center"><b>Grocer</b></p>		11. BIRTHPLACE (City and State or Foreign Country) <p align="center"><b>Maysville, Missouri</b></p>	
12. CITIZEN OF WHAT COUNTRY? <p align="center"><b>USA</b></p>		13a. FATHER'S NAME <p align="center"><b>Robert A. Hewitt</b></p>		13b. MOTHER'S MAIDEN NAME <p align="center"><b>Catherine M. Dalrymple</b></p>	
14. NAME OF HUSBAND OR WIFE <p align="center"><b>Myrtelle</b></p>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <p align="center"><b>NO</b></p>		16. SOCIAL SECURITY NO. <p align="center"><b>unknown</b></p>	
17. INFORMANT'S SIGNATURE OR NAME <p align="center"><b>Mrs. Philip Hewitt, 210 1/2 S. 11th St., St. Joseph, Mo</b></p>		17. 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, asphyxia, etc. It means the disease, injury, or complication which caused death.	
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.		19. MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Chronic myocarditis</b> ANTECEDENT CAUSES <b>Arteriosclerotic heart disease</b> DUE TO (b) _____ DUE TO (c) _____ Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. II. OTHER SIGNIFICANT CONDITIONS <b>Carcinoma of prostate</b> <b>Old hip fracture</b> Conditions contributing to the death but not related to the disease or condition causing death.		INTERVAL BETWEEN ONSET AND DEATH <b>several yrs</b> <b>several years</b> <b>several years</b>	
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) <p align="center"><b>4200 H</b></p>	
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>2-28-56</u> , 19 <u>  </u> , to <u>4-1-56</u> , 19 <u>  </u> , that I last saw the deceased alive on <u>3-26-56</u> , 19 <u>  </u> , and that death occurred at <u>7:25a.</u> m., from the causes and on the date stated above.					
23a. SIGNATURE <p align="center"><i>E. Handley</i></p>		(Degree or title) <b>M.D.</b>		23b. ADDRESS <b>311 Physician &amp; Surgeon St. Joseph, Missouri</b>	
23c. DATE SIGNED <p align="center"><b>4-2-56</b></p>		24a. BURIAL, CREMATION, REMOVAL (Specify) <p align="center"><b>burial</b></p>		24b. DATE <p align="center"><b>4/4/1956</b></p>	
24c. NAME OF CEMETERY OR CREMATORY <p align="center"><b>Clarksdale Cemetery</b></p>		24d. LOCATION (City, town, or county) (State) <p align="center"><b>Clarksdale, Missouri</b></p>		25. FUNERAL DIRECTOR'S SIGNATURE <p align="center"><i>Heston - Bowman</i></p>	
25. ADDRESS <p align="center"><b>St. Joseph, Mo</b></p>		DATE REC'D BY LOCAL REG. <p align="center"><b>Apr 6, 1956</b></p>		REGISTRAR'S SIGNATURE <p align="center"><i>Kathleen M. Allison</i></p>	

(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.....  
Signature of Student Embalmer

Signed *Billie C. Gordon*.....

Licensed Embalmer No. *498*.....

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.