

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

26087

FILED SEP 10 1956

STATE FILE NUMBER

42

1000

957

Registration District No. Primary Registration District No. Registrar's No.

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Nodaway	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St Joseph		c. CITY OR TOWN Conception Jct., Mo	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION State Hosp. #2		Length of stay in 1b 4yrs 4mo	
Length of stay in 1b 4yrs 4mo		STREET ADDRESS not given (If outside, give location)	
Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) Loretto ^{First} Maher ^{Last}			4. DATE OF DEATH Month 8 Day 30 Year 1956		
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5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 1, 1894	9. AGE (In years last birthday) 62	IF UNDER 1 YEAR Months Days Hours Min.	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) Reg. Nurse & Housewife	10b. KIND OF BUSINESS OR INDUSTRY Nursing & Home	11. BIRTHPLACE (City and state or country) Clarksdale, Mo	12. CITIZEN OF WHAT COUNTRY? USA
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13. FATHER'S NAME John McManus	14. MOTHER'S MAIDEN NAME Fanny Rooney
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. none	17. INFORMANT Address William M Maher-Conception Jct. Mo
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of colon right lower quadrant		INTERVAL BETWEEN ONSET AND DEATH 1 yr
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b)	
	DUE TO (c) Schizophrenia paranoid type	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour. Month, Day, Year a. m. p. m.		
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from Jan 1, 1956 to Aug 30, 1956 and last saw her alive on 8-30-56
Death occurred at 12:55 PM m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Forrest Thomas (Degree or title) M D	22b. ADDRESS 17. Nod Hosp No 2 St Joe, Mo	22c. DATE SIGNED 8-30-56
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 9/1/1956	23c. NAME OF CEMETERY OR CREMATORY St Columba Cemetery	23d. LOCATION (City/town or county) (State) Conception Jct., Mo
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24. FUNERAL DIRECTOR Registrar Address	25. DATE RECD. BY LOCAL REG. Sept 4, 1956	26. REGISTRAR'S SIGNATURE M. Allison
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(Licensed Embalmer's Statement on Reverse Side)

Health, & Welfare Public Service
300 1-56
Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

48 5

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.....
G. M. Atchue

Licensed Embalmer No... *23*

P. O. Address *Maryland*

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.