

FILED MAR 25 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH7672  
STATE FILE NUMBER

295

Registration District No. 42 Primary Registration District No. 1000 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 Buchanan					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN St. Joseph 0117		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Joseph's Hosp.			Length of stay in lb Life		d. STREET ADDRESS (If outside, give location) 2215 Edmond St.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First John Middle L. Last Hafner				4. DATE OF DEATH Mar. 15, 1957 Month Day Year					
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 20, 1897		9. AGE (In years last birthday) 59	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk			10b. KIND OF BUSINESS OR INDUSTRY Grocery		11. BIRTHPLACE (City and state or country) St. Joseph, Mo.		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Remig Hafner				14. MOTHER'S MAIDEN NAME Therisia Feidler					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 491-09-3765		17. INFORMANT Mrs Beaufort F. Webster 2215 Edmond St. Joseph, Mo.			Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Empyema left thoracic cavity</i> DUE TO (b) <i>Cause undetermined</i> DUE TO (c) Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(n) <i>Post Encephalitis Parkinson's Disease</i>							INTERVAL BETWEEN ONSET AND DEATH undetermined		
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.)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m.									
20d. INJURY OCCURRED WHILE AT WORK <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 3-8-57 to 3-15-57 and last saw <sup>her</sup> him alive on 3-14-57 Death occurred at 6:50 a m on the date stated above; and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) <i>George W. Ferrans M.D.</i>				22b. ADDRESS 902 Edmond St. St. Joseph			22c. DATE SIGNED 3-15-57		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Mar. 18, 57	23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		23d. LOCATION (City, town, or county) St. Joseph, Mo.		(State)		
24. FUNERAL DIRECTOR <i>Hermon W. Sideman</i> ADDRESS <i>St. Joseph, Mo.</i>			25. DATE RECD. BY LOCAL REG. <i>March 20, 1957</i>		26. REGISTRAR'S SIGNATURE <i>Esther M. Allison</i>				

(Licensed Embalmer's Statement on Reverse Side)

Health, Welfare, Public Service

300-56

Diseases in Part I must be causally related. Careener cannot certify to a death due to natural causes. Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. At

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Dr. Forman

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.....  
*Robert H. Gyle*

Licensed Embalmer No. 330

P. O. Address *St. Joseph*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.